# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 12/20/2010 STATEMENT OF DEFICIENCES FORM APPROVED (X1) PROMDÉRISUPPLIERICLIA IDENTIFICATION NUMBER: WID PLAN OF CORRECTION OMB NO. 0938-0391 (PZ) MULTIPLE CONSTRUCTION OCS) DATE SURVEY A. BUILDING COMPLETED 09G224 NAME OF PROVIDER OR SUPPLIER B. WING R-C 12/16/2010 STREET ADDRESS, CITY, STATE, ZIP CODE CARECO 606 1/2 STTH STREET NE WASHINGTON, DC 20019 (X4) ID SUMMARY STATEMENT OF DEPICENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PROVIDER'S PLAN OF CORRECTION TAG (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG COMPLETION CROSS-REFERENCED TO THE APPROPRIATE (W 000) INITIAL COMMENTS DEFICIENCY) **(W 000)** A follow-up survey was conducted on December 15, 2010 to verify that the facility had implemented their plan (submitted December 14, 2010) to resolve an Immediate Jeopardy (IJ) that was found to exist on November 29, 2010. Through observations of the clients and their adaptive equipment, interviews with direct support, nursing and administrative staff as well GOVERNMENT OF THE DISTRICT OF COLUMNA as a review of the clients' records, the DEPARTMENT OF HEALTH determination was made that the facility had not HEALTH REGULATION ADMINISTRATION taken sufficient corrective action to remove the 825 NORTH CAPITOL ST., N.E., 2ND FLOOR U. Specifically, the facility failed to provide WASHINGTON, D.C. 20002 transportation services and/or necessary adaptive mobility equipment to ensure that two (out of six) clients received outside medical services. [See W127] Previously, on November 24, 2010, at approximately 6:24 p.m., the Health Regulation and Licensing Administration 's (HRLA), Compliance and Quality Assurance investigation Division (CQAID) was notified by volcemail of the death of Client #1. According to the message, the client fell from his wheelchair, sustained a head injury and subsequently died while at the hospital. On November 26, 2010, the CQAID initiated an investigation to determine the facility's compliance with both Federal participation and local licensure requirements for Intermediate Care Facilities for Persons with Intellectual Disabilities (ICFID) participating in the Medicald program. On November 29, 2010, the Intermediate Care Facilities Division (ICFD) received a complaint from the Department on Disability Services that BORATORY OFFECTOR'S OR PROVIDENSUPPLIER REPRESENTATIVE'S SIGNATURE y deficiency experient ending with an asteriek (\*) denotes a deficiency which the institution may be excised from correcting providing it is determined that other sequencie provide sufficient protection to the patients. (See instructions.) Except for rurating homes, the findings stated above are discloseble 90 days following the sec documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation. Director of Disability nterim

# DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/20/2010 CENTERS FOR MEDICARE & MEDICARD SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROMOERIGUPPLIERICUA AND PLAN OF CORRECTION (02) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: (XX) DATE SURVEY A BUILDING COMPLETED B. WING 00G224 R-C NAME OF PROVIDER OR SUPPLIER 12/15/2010 STREET ADDRESS, CITY, STATE, ZIP CODE CARECO ME 1/2 STITH STREET ME WASHINGTON, DC 20019 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES EACH DEPICIENCY MUST BE PRECEDED BY FULL Ð FROMDER'S PLAN OF CORRECTION TAG REGULATORY OR LIC IDENTIFYING INFORMATION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERIENCED TO THE APPROPRIATE (AS) COMPLETION DATE TAG DEFICIENCY **(W 000)** Continued From page 1 (W 000) alleged clients in the facility did not have necessary adaptive equipment. The complaint further alleged that needed medical services were not being provided and the facility falled to implement dietary orders and mealtime protocols as required. A monitoring visit/investigation was initiated by the iCFD into the following allegations on November 29, 2010: 1. Client #2's "wheelchair gumey" was reported by his occupational therapist (OT) as broken beyond repair. Allegation was substantisted. 2. Client #2's scheduled medical follow up appointments, i.e., his annual ophthalmology follow up for glaucome and annual urology, have been cancelled due to "transportation" issues related to his wheelchair gumey. Allegation was substantiated 3. Client #2's labs ordered by his primary physician on September 1, 2010, have not been completed. The nurse stated that the labs have not been completed due to the "transportation" issues. Allegation was substantiated 4. Client #2 is prescribed a low fat, low cholesterol purped diet with nectar thickened liquids. On the date of the review, November 23, 2010, Client #2's liquids were not presented in accordance to his prescribed diet and texture. He was provided "boost" liquid which was not thickened. Allegation was not substantiated 5. Client #2 has a mealtime positioning plan to address his risk of aspiration and choking. His

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 12/20/2010 FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROMDERSUPPLIENCLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (XZ) MULTIPLE CONSTRUCTION (CS) DATE SURVEY A BUILDING COMPLETED 000224 B. WING R-C NAME OF PROVIDER OR SUPPLIER 12/15/2010 STREET ADDRESS, CITY, STATE, ZIP CODE CARECO IGG 1/2 67TH STREET ME WASHINGTON, DC 20019 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION PROMDERS PLAN OF CONRECTION (EACH CONNECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE PREFIX D PREFE COMPLETION TAG DEFICIENCY) (W 000) Continued From page 2 **(W 000)** plan includes elevating the head of his bed to a 20 degree angle and the using a positioning wedge to elevate the client an additional 50 degrees during and following his mealtime. On the date of the review, he was not properly positioned during his meetime as recommended. Allegation was not substantiated 6. The home has no system in place by which to monitor Citent #2's weight. A wheelchair scale is in the home but is not currently operational. Allegation was substantiated 7. Although the nurse and Qualified Mental Retardation Professional (QMRP) are aware that Client #2's weight is not being obtained or monitored, there is lack of monitoring of Client #2's food intake. Allegation was partially substantiated 8. The facility does not have a positioning plan in place to address Client #2's skin integrity. Allegation was substantiated 9. The facility was not monitoring/documenting Client #2's bowel movements. Allegation was not substantiated The findings of the monitoring visit/investigation were based on observations at the group home, interviews, and the review of clinical and administrative records, including incident reports. Six of the seven clients currently residing in the facility were reviewed. One additional client's

record was reviewed for the death investigation. The results of the monitoring visit/investigation revealed that conditions found, posed an immediate and serious threat to the health and

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<b>(W 000</b> )	Continued From p	ige 3	{W 00				
	Services (DDDS) was departly (LJ) exists the DDDS submitted however the plan was initiated on Cilcular department of the injury was unknowned that the investigation into the includes deficiencies investigation into the investigat	IG BODY AND  sure that specific governing out requirements are met.  not met as evidenced by: and record review, the ody failed to develop and ad precedures to ensure a sand operable wheelchair of the ensure affective stem.		W102 This CONDITION will follows: Careco has implemented Adaptive Equipment Proensure each client has sat operable adaptive equipmincludes quarterly preventeviews from PT & OT. Recommendations pertain equipment will be review QMRPs and the Deputy I. This information will be to an interdisciplinary teat included in the Quality Imreports which shall be reported in the Quality Imreports which shall be reported in the QMRPs, Residence Direct Support Staff who were trained on the implementation of the Adaptive Equipmental Direct Support Staff who were client #2, #3, #4, #5 and # been trained on it.	a new tocol to fe and nent which tative  ning to this ed by the Director. orwarde n and proveme proted out ine basis rectors, s have nentation Policy On. All	3.7.11	
	mplemented to ensure ind W192]. The effects of these sesuited in the Govern	e client safety. [See W189			3/7/11		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/20/2010 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED MB NO. 0038-0391 STATEMENT OF DEFICIENCES (X1) PROVIDER GUPPLIERICUA (92) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (CS) DATE BURNEY DENTIFICATION NUMBER A. BLELDING COMPLETED B. WING R-C 00G224 12/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **CARECO** OOS 1/2 STITH STINEST NE WASHINGTON, DC 20019 OLA) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC EDENTIFYING SIFORMATION PROVIDER'S PLAN OF CORRECTION Ð (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE (XS) COMPLETION TAG DEFICIENCY (W 102) Continued From page 4 (W 102) W104 manage the facility in a manner that would This CONDITION will be met as ensure clients' health and safety. [See W122] evidenced by: {W 104} 483.410(a)(1) GOVERNING BODY **(W 104)** 1. Careco has implemented a protocol for tracking the status of The governing body must exercise general adaptive equipment and has trained policy, budget, and operating direction over the staff on its implementation. Careco facility. has made alternative arrangements for clients to receive in-home medical care when the status of their adaptive equipment prevents them This STANDARD is not met as evidenced by: from leaving the home. Alternate Based on observation, interview, and record arrangements include PCP providing review, the facility's Governing Body failed to services in the home, in-home labs, provide general operating direction, for six of the hiring a recreational therapist, using seven clients residing in the facility. (Clients #1, loaner wheelchairs/adaptive #2, #3, #4, #5 and #6) equipment, using transportation vendors and receiving in-home The findings include: community integration. This information will be forwarded to an 1. [Cross-refer to W127 and W136] The interdisciplinary team and included 1-19-11 Governing Body failed to protect and ensure the in the Quality Improvement reports health, safety and community integration of each which shall be reported out to senior client by making certain that adaptive equipment leadership on a routine basis. was furnished and maintained in good condition (wheelchairs, air mettresses, shower chairs and 1/19/11 or/gumeys). 2. Careco Inc has implemented an 2. [Cross-refer to W149] The Governing Body adaptive equipment protocol that failed to develop policies and procedures on 1.30.11 outlines the procedure for tracking wheelchair monitoring to ensure client safety. adaptive equipment including (W 122) **483.420 CLIENT PROTECTIONS** (W 122) wheelchair monitoring in the homes. On a quarterly basis, OT/PT will The facility must ensure that specific client review adaptive equipment as part of protections requirements are met. a preventative maintenance measure. Concerns pertaining to adaptive equipment will be reviewed by the Quality Improvement Committee This CONDITION is not met as evidenced by: where an interdisciplinary team will Based on interview and record review, the facility provide appropriate care solutions.

Event ID:PC1312

Facility ID: 093224

I/30/11

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	failed to ensure sy implemented to m subjected to physic to ensure that clier outings in accordar [See W136]; failed procedures that en safety [See W149] injuries of unknown W153].  The effects of these in the failure of the and ensure their he w158] 483.420(a)(5) PRO RIGHTS  The facility must en Therefore, the facility must en Therefore, the facility are not subjected to psychological abuse.  This STANDARD is Based on observation review, the facility fasefety of each client adaptive equipment maintained in good a shower chairs and/or and/or provided transof the six clients curr (Clients #2, #3, #4 author findings include:  1. On December 15.	stems were designed and/or alte certain clients were not cal injuries [See W127]; failed its participated in community nee with their annual plans to implement policies and sured clients' health and; and failed to ensure that all a origin were reported [See a systemic practices resulted facility to protect its clients alth and safety. [Also see TECTION OF CLIENTS  sure the rights of all clients by must ensure that clients or physical, verbal, sexual or or punishment.  In not met as evidenced by: or, staff interview and record alied to ensure the health and by making certain that was furnished and condition (wheelchairs, gurneys) as prescribed sportation services, for four ently residing in the facility. and #5)	{W 12		W122 This CONDITION will be n follows: Protocols have been put in plensure that physical injurical clients are minimized. The adequipment protocol includes safety measures such as: - Alternate arrangements for a to receive community of accordance to their annual plan response to W136] Current policies and protocols been created and implement ensure the health and safety and clients in our care[See response to W149] and have been retrained to ensure the incidents of unknown origin reported. [See response to W155]	ace to es to aptive client clients utings s [See s have ed to of the staff nat all n are	12.31.10

### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/20/2010 CENTERS FOR MEDICARE & MEDICARD SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCES (X1) PROVIDERIGUPPLIERICLIA 0(2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION OCS) DATE SURVEY DENTIFICATION NUM COMPLETED A BUILDING R-C B. WING 000224 NAME OF PROVIDER OR SUPPLIER 12/15/2010 STREET ADDRESS, CITY, STATE, ZIP CODE **CARECO** 506 1/2 STTH STREET NE WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCES (X4) ID (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IN PREFIX (AB) MEPLETION DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICENCY (W 127) Continued From page 6 (W 127) outside medical services, as evidenced below: W127 This STANDARD will be met as a. Client #2 was observed in his hospital bed follows: when the revisit began, at 7:48 a.m. At 12:30 1. a-c Client #2 Wheelchair p.m., a new custom molded gumey wheelchair was delivered on 12/15/10. was delivered to the facility by the wheelchair The PT came to assess the vendor. However, interview with the Interim Client #2 wheelchair on Director of Developmental Services (IDDS) 12/17/10. Careco Inc has a revealed that the physical therapist (PT) would wheelchair van that will be first need to assess the new gurney wheelchair to fitted ťΩ accommodate verify that it meets Client #2's specific needs. As 2.30.11 Client #2 wheelchair. In the of 5:33 p.m., the facility had not secured an event that this vehicle is not appointment with the PT. functioning or Client #2 wheelchair is broken, he At 5:25 p.m., interview with the facility's quality will be transported by a assurance (QA) specialist revealed that he had transportation company to just taken measurements of Client #2's new his medical appointments. gumey wheelchair. He questioned whether the Client #2 blood and urine vehicle previously-identified for transporting the levels were obtained by client would be able to accommodate the Genesis I Phlebotomy wheelchair. He further indicated that he would Service Inc on December have his "specialist" examine the vehicle and 15, 2010 according to the determine whether the facility would need to RN the levels were within order additional tie down straps. normal limits. The new QMRP for the home was In the facility's letter in response to the trained on the adaptive Immediate Jeopardy (LI), dated December 14, equipment protocol that 2010, the facility stated, "arrangements have includes documenting the been made with <transportation vendor> to status on progress notes of transport Client #2 to medical appointments in all adaptive equipment. the absence of his wheelchair." At 1:40 p.m., interview with registered nurse (RN) revealed 2. a-b Client #2 Wheelchair that an application form for such services had been maintained been transmitted via facsimile to the according to Careco Inc.

transportation vendor on the day before

(December 14, 2010). According to the IDDS, at 3:25 p.m., the application process required 24-48 hours to determine his eligibility for services. Moments later, review of the application form

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	2010 to December 2 make it to the Dece Similarly, he missed urology appointment scheduled for November 15, 2010 transportation service receiving medical set. It should be noted Client #2 remained with the second 719A form his shower gumey. She was signed by the PC Moments later, review mental retardation prote on adaptive equipments. In the meaning order on December 8 continue receiving be shower gumey.	2, 2010. He did not, however, mber 2, 2010 appointment. It a December 10, 2010 it which had originally been mber 9, 2010. As of , Client #2 remained without less and was, therefore, not prvices outside of the facility.  I that on December 15, 2010, without a shower gurney, two indered by the PCP. At 9:45 the IDDS revealed that a not been submitted for the presented a 719A form that CP on November 30, 2010, w of the client's qualified original (QMRP) progress ipment, dated December flect the status of the shower time, the PCP wrote an 1, 2010, for Client #2 to ad baths while awaiting the	(W 1:	27)			
l	<ol> <li>The facility failed wheelchair to ensure ( medical services, as e</li> </ol>	to maintain Client #3's that he received outside evidenced below:				To provide the latest and the second	12:31:10
h v s p d	2:45 p.m., Client #3 to pital bed. At 12:3 tendor arrived in the fafety belt on the client.m., interview with the ay before (December the client have the wheelchair with the wheelchair whee	2010, from 7:48 a.m. until was observed in his 0 p.m., the wheelcheir acility and repaired the it's wheelcheir. At 12:43 a LPN revealed that on the 14, 2010), Client #3's d been loose on the right as deemed unsafe. The that because the seetheir		And the second s			

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	missed two medical clinic and PCP) that December 14, 2010  At approximately 1:4 RD and IDDS revea the loaner wheelchai previously, on Decemoning of December of the seathelt had "conference, at 5:00; acknowledged that it another wheelchair a previous day, to ensi appointments.  b. In the facility's lettinmediate Jeopardy 2010, the facility state the Medicare process molded wheelchair fovendor> had indicate requesting face-to-face before they will authowheelchair." At approximaterview with the LPI had not had a "face-to-face they will authowheelchair as to receive a and a rolling shower cost. She presented the pcp. At approximaterview with the RN interview with the RN intervi	d property, the client had appointments (wound care were acheduled for	(W1	273	DEACENCY)		
10	n December 14, 2010 hat the PCP "sees him	7. They further employees				***************************************	

STATEME	TOP DEFICIENCIES OF CORRECTION	(XI) PROVIDENSUPPLIENCIA DENTIFICATION NUMBER:	A. BUILDIA	IPLE CONSTRUCTION IG	OMB NO	COMB NO. 0836-034 (CS) DATE SURVEY COMPLETED R-C	
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	3. On December 1 44 was observed a wheelchair's anti-til interview with a dis working with the cit anti-tippers were us wheelchair from tip up a hill. The staff the anti-tippers sho a.m., the staff was toward the door. To up position. At 9:19 position. At 9:19 position. At 9:19 position. When browners later, the anti-tippers were in then intervened and reposition the anti-tippers were in then intervened in the down position of the d	is, 2010, at 8:37 a.m., Client eated in his wheelchair. The ppers were in the up position. Wet support staff who was lent indicated that the sed to help support the sed to help support the sping backwards, when going did not, however, state how util be positioned. At 9:07 observed propelling the client he anti-tippers were still in the 5 a.m., the RD was observed utside towards the van. ers remained in the up sught to her attention a few IDDS acknowledged that the the up position. She (IDDS) I instructed the staff to instructed the staff to instructed the staff to ppers in order for them to be and direct support staff sed the anti-tippers to the stafe the client's safety. We telephone at 8:50 a.m., the tated "the anti-tippers should fon whenever the wheelchair did be noted that review of the rois, at approximately 2:30 on December 8, 2010, facility sining on safety and chairs. Observations on the or 15, 2010, however, ining had not been effective.  Iter in response to the (IJ), dated December 14.	(W 127)			12.17.10	

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	stretcher for bathing 8:20 a.m., inspection confirmed that the sign had indeed been represented without a there was no evider had brought the occurrence of the common stretcher to support the first stretcher to support the first stretcher to support the common stretcher to support the first stretcher to support the supp	anded shower gamey  December 15, 2010, at a of the client's wheelchair safety strap on the left footreet paired. The client, however, shower gamey stretcher, and represented that the QMRP supational therapist's recommendation for a shower the PCP's attention.  The Deficiency Report dated included the following:  If from head injuries an his wheelchair on was admitted to the facility  2010, at approximately 6:10 he qualified mental had (QMRP) revealed that been admitted with a sicheir. The wheelchair, as repossessed by the corily thereafter, due to prent. [Note: The QMRP tast date and review of the last date date date date date date date dat	(W 1	127)	Federal Deficiency Report 12/2 W127 This STANDARD will be a follows:  1. a-e The new QMRP here been trained on the Adaptive Equipment Protocol and Careco In Adaptive Equipment Pand Procedure. The Qwill be expected to train and report the status of adaptive equipment in timely fashion according the Adaptive Equipment Protocol. DSP staff in home have been trained documentation and verification of adaptive equipment. The QMPP has been trained the expectations around documenting adaptive	as as as ac olicy MRP ck a ag to at the i on bally e on	2.30.11
	the exact date on whi wheelchair was remo- Further interview with December 2000, the i of the client's attorney xistom molded wheel illegedly had been us	at evening falled to identify ch his custom molded wed from the facility.] the QMRP revealed that in facility enlisted the support y in an effort to secure a chair that Client #1 ing while residing with a se efforts, however, failed			equipment. QA monito the home with the repor completed and findings shared with the QMRP 10/20/10. This was available for at the time the survey. In the future, individual will be transported without adap	on of no	

		TH AND HUMAN SERVICES RE & MEDICAID SERVICES			FORI	D: 12/20/2010 M APPROVED D. 0938-0391
TATEMEN	IT OF DEFICIENCIES OF CONRECTION	(X1) PROVIDERIGUPPLIERICLIA SDENTIFICATION NUMBER:	(XZ) MA A. BUIL	ATIPLE CONSTRUCTION ONG	(CS) DATE COMP	SURVEY LETED
		00G224	S. WIN	8	•	R-C 16/2010
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COX 606 1/2 STTH STREET ME WASHINGTON, DC 20019		10/2010
(XA) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEPOENCES BY MUST BE PRECEDED BY PULL. LISC IDENTIFYING INFORMATION	ID PREFID TAG	PROVIDER'S PLAN OF COR	HOULD SE	COMPLETION DATE
(W 127)	and the QMRP ac had not initiated to obtaining a new or	knowledged that the facility ne formal process towards ustom molded wheelchair.	{W 12			
	a.m., review of Cil records revealed of obtain a custom m PT evaluation, dai included "consider system." Then on documented that it sling type seating of that time of his de wrote "He sits on h shifted right. Then right addia from the system perpetuate He is at rick of skin recommended a cu the open tempetuate the appropriate wh "Follow-up with new October 4, 2010, th annual evaluation a same recommenda wheelchair. The go	io, 2010, beginning at 10:00 fert #1's physical therapy (PT) ingoing recommendations to tolded wheelchair. His annual ad September 22, 2008, a custom molded seating October 13, 2008, the PT he standard wheelchair, with the one the client was using at with) was inappropriate. He is right litum. His trunk is a is increased pressure on his increased pressure on his inght arm rest. The seating is his scollosis and deformities, is breakdown." The PT again istom molded wheelchair. In industion, dated October 15, the client "had not received seichair" and recommended with custom wheelchair." On the PT performed another at which time he repeated the dion for a custom molded weming body failed to address the for a custom molded.		equipment in proper working condition ar QMRP will be expect address all adaptive equipment needs in a fashion.	ted to	
	therapy (OT) record beginning at 10:15 a repeatedly document wheelchair did not re evaluation deted Sa 'the wheelchair is w	of Client #1's occupational is on November 30, 2010, a.m. revealed that the OT had need that the OT had need his needs. An OT ptember 14, 2009, included ide and the seat and back do pport. He is at great risk for				

		TH AND HUMAN SERVICES RE & MEDICAID SERVICES			FORM	): 12/20/2010   APPROVED  . 0938-0391			
TATEMEN	T OF DEFICIENCIES OF CONNECTION	(X1) PROADENBUPPLERICLIA EXENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(AS) DATE ( COMPL	ETED ETED			
	· ·	003224	B. WING			₹-C 1 <b>5/201</b> 0			
NAME OF F	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZP CODE 606 1/2 67TH STREET ME WASHINGTON, DC 28019						
(X4) ID PRIEFIX TAG	EACH DEMORN	TATEMENT OF DEPICIENCIES OF MUST BE PRECEDED BY PULL LISC IDENTIFYING INFORMATION)	ED PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CONNECTIVE ACTIO CROSS REPENDINCED TO THE DEPICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETION DATE			
	falls and skin bree wheelchair evalua strongly recomme recent OT Evaluate 2010, recommend and a new wheelch the OT again note "does not provide positioning." Later sustaining a fall of the extension of the lightest sustaining a fall of the extension of the lightest sustaining a fall of the extension of the lightest sustaining a fall of the extension of the lightest sustaining a fall of the extension of the exte	stidown in this chair. A new tion and new wheelchair are nded" The client's most tion, dated September 11, led a wheelchair assessment hair. On November 1, 2010, d that the standard wheelchair optimal balance, posture, or rithat month, the client died head injury.  19, 2010, at 11:30 a.m., w with the direct support staff leisted Client #1 out from the ift on the day that he fell fo), revealed that the buckle his wheelchair had been knalely 30 days." There was wer, that the facility attempted left repaired. On November 29, observation of the wheelchair est belt was indeed broken. In ing on the right arm rest was he metal frame of the arm rest lients #1 wheelchair were an HRLA recertification inted August 20, 2010. There lowever, that the governing	(W 127)						
	body implemented since it was submit The QMRP had no Client #1's records there was no evide monitoring since the 2. Client #2 was ad	their Plan of Correction (PoC) ted on September 23, 2010. I maintained running notes in regarding needed repairs and noe of quality assurance (QA) e August 20, 2010 survey.  mitted to this ICF/ID on Client #2 did not receive							

		TH AND HUMAN SERVICES				:D: 12/20/2010 IM APPROVED
		E A MEDICAID SERVICES				O. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/GUPPLER/CLIA IDENTIFICATION NUMBER:		ALTIPLE CONSTRUCTION R.DING	(CI) DATE	SURVEY PLETED
		003224	B. WI	NG	40	R-C
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		V18/2010
CAREC	0			606 1/2 87TH STREET NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	EACH DEFICIENT	TATEMENT OF DEFICIENCIES BY MUST BE PRINCIPED BY PULL. LEC IDENTIFYING INFORMATION)	D PREF TAG	TX (EACH CONNECTIVE ACTI	ON SHOULD SE HE APPROPRIATE	COMPLETION DATE
(W 127)	Continued From p	age 14	{W 1	273		
	wheelchair, shows to his existing ada below:  a. On November 2 repairmen was obted located in a bilicensed practical head of this hospital head of this hospital head was not demonstrated succeptable of the LPN informed thospital bed was not demonstrated succeptable of the was September 7, 2010.  b. On November 2 #2's custom molde observed being sto explained that the instruction of the control	9, 2010, at 3:50 p.m., Client d gumey wheelchair was red in a supply room. It was nd the evening nurse		2. a-d QMRP and Ribeen retrained on Adaptive Equipment concer documented. Car using a vendor to in-home laborator when an individual unable to leave the In the future, QM ensuring that Cliegoals are met utilical appointment community outing Arrangements have made for Client # to visit him in the way to assist him maintaining relation. The Primary Carefor Client #2 has the use of bed bar absence of a show	the new ent /e ns are eco Inc is provide y services al is e home. RP is nt #2 ISP izing tation to ogram, eents and gs. ve been 2 friends home as a in ionships. e Physician ordered ths in the	12.8.10

CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES					APPROVED  ), 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENCIA IDENTIFICATION NUMBER:	(X2) I A. BL		IPLE CONSTRUCTION IS	(CS) DATE SLIRVEY COMPLETED		
		0 <b>0</b> G224	B. W	NG_		i '	R-C 1 <b>6/2010</b>	
CARECO				1	REET ADDRESS, CITY, STATE, ZP CODE 166 1/2 67TH STREET NE MASHINGTON, DC 20019		16/20/10	
(X4) ID PREFIX TAG	<b>EACH DEFICIENCY</b>	(TEMENT OF DEPICIENCES Y MUST BE PRECEDED BY PULL BC (DENTIFYING INFORMATION)	ID PREI TAC	<b>T</b> K	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEPICIENCY)	AD BE	COMPLETION DATE	
	insurance company Client #2 remained gurney wheelcheir is hospital bed, within c. On November 30 p.m., review of Clie revealed that he has urology appointment November 3, 2010 a respectively. In add physician (PCP) had physician (PCP) had 2010, laboratory stutes and lipid profile confirmed that the cophthalmology and the lack of a gurney appointments had be December 2010,] A there was no finalize laboratory studies on Since being confirmed that his community integration of the had not left the facommunity integration of the facommunity integration of the had not left the facommunity integration of the facomm	without a custom moided and was confined to the the facility.  2010, beginning at 6:00 at #2's medical records a missed ophtheimology and its originally scheduled for and November 9, 2010, litton, the primary care of ordered on October 1, dies for "CBC, CMP, UA, b." At 7:00 p.m., the QMRP lient had missed his prology appointments due to wheelchair. [Note: The sen rescheduled for sof that evening, however, and plan for obtaining the clered on October 1, 2010, if to the hospital bed, Client will and, therefore, his on was restricted. It should ividual Support Plan (ISP) 2009, indicated that "going to community outings" were int to him. The ISP also and that I maintain optimal neelchair that is in good ionships."	<b>(W</b> 1	27}				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		TH AND HUMAN SERVICES BE & MEDICAID SERVICES				FOR	D: 12/20/2010 M APPROVED D. 0938-0391
	IT OF DEFICIENCIES OF CONFECTION	(X1) PROMOENGUPPLERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(CS) DATE SURVEY COMPLETED	
		000224	B. WA	NG			R-C
CAREC				805	ET ADDRESS, CITY, STATE, 22º CODE 1/2 STTH STREET NE ISHINGTON, DC 20019		15/2010
(X4) ID PREPX TAG	EACH DEFICIENC	ATEMENT OF DEPICIENCIES  Y MUST BE PRECEDED BY PULL.  LBC IDENTIFYING INFORMATION	ID PRES TAG	ex	PROMDER'S PLAN OF CORRECTION SH (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEPICIENCY)		COMPLETION DATE
(W 127)	Continued From po	nge 16	{W 1	271		<del></del>	
	that Client #2 needed "a shower gurney."		ţ-u .				
	the facility on Augureceive new adaption and/or timety repair equipment, as evided. A. On November 2: #3 was observed sibulation. His when the bedroom: His when the bedroom; its left interview with the extrement had white a the bottom of one of interview revealed it used the tape to see however, the tape to 7:20 p.m., interview revealed the chair had that the nursing home to the with that wheelchair condition at that times and the condition at that times are conditions at the condition at th	R, 2010, at 3:45 p.m., Client eeping in a hospital bed in his sichelr was observed across it armirest was detached. Wening LPN revealed that the cently broken. The detached idheave tape wrapped around its supports. Further that facility staff previously cure the armirest to the chair; was no longer effective. At with the CMRP and RD and broken a week earlier, had been admitted from a facility on August 5, 2010, which was in operational e.			3. a-c The QMRP and RD have been trained on th timely acquisition and repair of adaptive equipment. In the futur QMRP will follow-up i timely fashion, docume and report any concerns barriers in obtaining adaptive equipment.	e the n a nt	128-10
	review of Client #3's 2010, confirmed the that it was functioning the record documentation of who to the record at 2:00 p.m. records revealed the while in the nursing I were taken for a cust august 9, 2010, the in custom molded who	010, beginning at 11:18 a.m., ISP, dated September 7, the utilized a wheelchair and ag at that time. Further, however, failed to show ten the wheelchair fad a., review of Client #3's PT at he had been assessed from and measurements from molded wheelchair. On PT again noted the need for selchair. Further review a form was generated on					

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391		
	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDERMUPPLIERCLIA IDENTIFICATION NUMBER:	()(2) i		TIPLE CONSTRUCTION NG	(CS) DATE SURVEY COMPLETED		
		00G224	a, w	NG_		1	R-C	
CAREC	PROVIDER OR SUPPLIER			1 (	TREET ADDRESS, CITY, STATE, 2P CODE 606 1/2 5/TH STREET ME WASHINGTON, DC 20019	<u>i 12</u>	18/2010	
(X4) ID PREFIX TAG	EACH DEPICIENC	ATEMENT OF DEPICIENCIES Y MUST BE PRECEDED BY FULL LEC IDENTIFYING INFORMATION)	ED PREI TAX	TX.	PROVIDER'S PLAN OF CORREC (EACH CORNECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEPICIENCY)	LORE	COMPLETION DATE	
	September 28, 20 four weeks passed wheelchair vendor the paperwork for a company." In a left the wheelchair ven problems with the CMRP stated that client's Medicare of November 30, 2 functioning wheeld b. On November 21 GMRP and RD stated decubitus uicer on admitted to the facilities on November 28, 2011 ordered a "rolling should be a facilities on November 30, 2011 ordered a "rolling should be a facilities wheelchair vendor wrote that the seperwork for approximately stated that all litent's Medicare can followers with the client's Medicare can followers and 20, 20	10, six weeks later. Another then on October 20, 2010, the wrote they "will be submitting approval by the insurence for dated November 30, 2010, dor indicated there were client's Medicare number. The she had given the vendor the ard later on that same day. As 010, the client was without a hair.  10, 2010, at 7:20 p.m., the led that Client #3 had a his secral area when he was lity. On November 30, 2010, or of Client #3's PT records in mattrees to promote skin m., further interview with the at the client received the air ber 13, 2010, almost three recommended by the PT.	(W1	273				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

## PRINTED: 12/20/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES MB NO. 0936-0391 (XI) PROVIDERBUPPLIERICLIA STATEMENT OF DEFICIENCES OC) MULTIPLE CONSTRUCTION (AS) DATE SURVEY COMPLETED IND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING S. WING. 066224 12/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 506 14 STTH STREET NE CARFCO WASHINGTON, DC 20019 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CONVECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE EACH DEPCENCY MUST BE PRECEDED BY PLAL REGULATORY OR LISC EXENTIFYING INFORMATION COMPLETION PREFE TAG DEFICIENCY (W 127) Continued From page 18 (W 127) 4. According to a Plan of Correction (PoC) dated 4. a,b Client #4 wheelchair has September 23, 2010, the OMRP indicated that been repaired, he will use repairs would be made to Client #4's wheelchair. this wheelchair until his As of November 30, 2010, the client's wheelcheir custom wheelchair is still had not been repaired and the condition of received. The OMRP has 128.10 his wheelchair placed him at risk, as evidenced been retrained on new below: Adaptive Equipment Protocol that outlines the a. On November 30, 2010, at 9:20 a.m., Client process for the timely #4 was observed seated in his wheelchair on the acquisition and repair of lift mechanism of the facility's van. At the time. adaptive equipment. staff were loading clients to go to day program. 12/8/10 inspection of his wheelchair revealed that in addition to the previously identified repairs needed (mismatched wheels), the right anti-tipper was missing and the safety straps on both foot rests were unattached. After the problems with his wheelchair were brought to the staffs' attention, they continued to put him on the van. At that moment, surveyors intervened and asked staff if they were aware of the administrator's directive regarding wheelchair safety and not leaving the facility. Staff then indicated that they were not aware of their administrator's directive that had been issued the previous evening. Once they were informed of the directive ("client will not be transported in... a wheelchair until it is properly repaired"), staff began wheeling Client #4 toward the facility. The client's right foot was observed dragging against the cement walkway for approximately four feet

as they made their way back to the home.

September 11, 2010, in which, the OT recommended that Client #4 receive \*a wheelchair consult as current wheelchair is too

Record review on November 30, 2010, beginning at 9:50 a.m., revealed an OT evaluation, dated

# PRINTED: 12/20/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES **4B NO. 0938-0391** STATEMENT OF DEFICIENCES WED PLAN OF CORRECTION O(1) PROMORRIGUPPLIENCLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SLAWEY DENTIFICATION NUMBER: COMPLETED A BUILDING R.C B. WING 803224 12/15/2010 NAME OF PROMDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 806 1/2 STITH STIMEET ME CARECO WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION D GACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LISC IDENTIFYING INFORMATION CONFLETION DATE PREFIX TAG (EACH CONNECTIME ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DERCENCY (W 127) Continued From page 19 **(W 127)** small for his height." On September 28, 2010. the PT evaluated the wheelcheir and concurred, writing "Chair is too small. He is at risk for lower extremity injury." On the same day (September 28, 2010), the PCP ordered a new wheelchair and staned a 719A form. A month later, on October 20, 2010, the wheelchair vendor wrote that they "will be submitting the paperwork for approval by the insurance company." In a letter dated November 30, 2010, the vendor informed the facility that they had secured approval for the new wheelchair. Measurements still needed to be taken before an order could be placed and the "entire process should take about 30 days." b. In an HRLA recertification deficiency report dated August 20, 2010, the facility was cited for Client #4's wheelchair having "two different types of wheels ... rear left wheel was observed to have ridges in the tire while the right rear was observed to have a smooth tire." In their Plan of Correction (PoC), dated September 23, 2010, the facility stated that the "QMRP will contact the equipment vendor and have the chair repaired. The QMRP will maintain a log of contacts with the equipment vendor and follow-up to ensure that the repairs are effectuated as soon as possible," and "the QA will monitor for three months to ensure compliance." On November 30, 2010, beginning at 9:50 a.m., review of Client #4's record falled to show evidence that the QMRP had maintained a log of contacts with the equipment vendor and there was no evidence of QA (quality assurance) monitoring in accordance

with the accepted PoC.

5. The facility falled to maintain Client #5's wheelchair safety and obtain a shower gumey stretcher for bathing, as evidenced below:

### PRINTED: 12/20/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES MB NO. 0938-0391 STATEMENT OF DEPICIENCES (X1) PROVIDER GUPPLERICUA IDENTIFICATION NUMBER: (42) MULTIPLE CONSTRUCTION OCH DATE BLIRNEY WID PLAN OF CONNECTION COMPLETED A BUILDING R-C B. WINE 08/3224 12/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SOS 1/2 STTH STREET NE **CARECO** WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES 044) ID PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE D (EACH DEFICIENCY MUST BE PRECEDED BY PULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) {W 127} Continued From page 20 (W 127) On November 30, 2010, at approximately 4:45 p.m., observation of Client #6's wheelchair revealed that the safety strap on the left footre was broken. At approximately 5:10 p.m., review of the client's record revealed an "OT Equipment 5. Client #5's Wheelchair has been repaired. In an Assessment," dated November 1, 2010, in which addendum to the November the OT identified the broken strap on the foot rest 30 OT note. The OT stated 11-1-10 and also recommended "a shower gumey ...[Client #5] has bathed stretcher for bathing." The QMRP was safely using the shower interviewed just minutes leter, at which time she chair. Shower chair can stated that she had not reviewed the OT's continue to be used for accessment prior to filling it in the client's records. bathing." In the future, the She indicated that she was unaware of the OMRP will use the damaged safety strap. She also acknowledged established protocols and that she was unawere that the OT had ensure repairs are obtained recommended a shower gumey for Client #5, in a timely fashion. four weeks earlier. 11/1/10 6. Client #6's wheelchair has 6. The facility felled to maintain Client #6's been repaired. In the future wheelchair safety by providing the footrest on his the QMRP will use the wheelchair, as evidenced below: established protocols and ensure repairs are obtained 12.13.10 On November 30, 2010, at 7:35 a.m., Client #6 in a timely fashion. was observed seated in his wheelchair in the 12/13/10 living room. The wheelchair was without a right footrest. At approximately 8:40 a.m., staff was asked about the missing footrest. The staff went to the client's bedroom and returned moments later stating that they were unable to find his footrest. At 10:15 a.m., staff indicated that Client #6 had stayed home from day program due to the condition of his wheelchair. Later that day, at 3:10 p.m., review of an OT evaluation, detect May 12, 2010, revealed that the OT had

identified a broken strap and foot plate. When interviewed a minute later, a daytime LPN and the Director of Nursing confirmed that the client had been in need of a new footreat for months.

	RTMENT OF HEALT ERS FOR MEDICAR	PRINTED: 12/20/2010 FORM APPROVED OMB NO. 0938-0391						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLETICLIA IDENTIFICATION NUMBER:	1,	WALTE REDOKE	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF CAREC	PROVIDER OR SUPPLIER O		······································	-	RET ADDRESS, CITY, STATE, ZIP CODE 6 1/2 67TH STREET ME ASHINGTON, DC 20019	1.6	197019	
(X4) ID PRIEFEX TAG	EACH DEFICIENC	ATEMENT OF DEPICIENCIES Y MUST BE PRECEDED BY PULL BC IDENTIFYING INFORMATION)	PREF TAG	K	PROMDERS PLAN OF CONRECT (EACH CORRECTIVE ACTION SHO) CROSS-REPERENCED TO THE APPR DEFICIENCY)	ACTION SHOULD BE COMPLETO THE APPROPRIATE DAT		
(W 127)	They explained the HMO) repeatedly in the wheelchair represent or replace the six month since the May 12, 2010.	ige 21 It his insurance company (an ind denied requests to have sired. The facility failed to e broken right footrest in the COT identified the need on OTECTION OF CLIENTS	{W1					
	The facility must en Therefore, the facility have the opportunity religious, and common This STANDARD is Based on observation	isure the rights of all clients, ity must ensure that clients y to participate in social, nunity group activities.  In not met as evidenced by: on, interview and record						
	participated in community their annual pla	miled to ensure that clients munity outlings in accordance ins, for two of the seven e facility. (Clients #2 and #3)				- Annual		
	admitted to this ICF/ On November 29, 20 custom molded gum being stored in a sur one side and the eve the frame was broke with the qualified me (QMRP) and residen evening, at 7:12 p.m gumey wheelchair ha when he was admitte broke, however, on S indicated that the gua	P127.2] Client #2 was P1D on September 7, 2010. P10, at 3:50 p.m., Client #2's By wheelchair was observed oply room. It was tilted to ming nurse explained that In. Simultaneous interviews intai retardation professional ce director (RD) inter that I., revealed that the client's ad been functioning properly od. The gurney wheelchair deptember 25, 2010. They may wheelchair was MRP presented her progress						

### FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>48 NO. 0938-0391</u> (X1) PROVIDENGLIPPLIENCLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCES 02) MULTIPLE CONSTRUCTION (X3) DATE SURVEY WID PLAN OF CORRECTION COMPLETED A SUILDING R-C B. WING 003224 12/16/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 606 1/2 67TH STREET HE CARECO WASHINGTON, DC 20019 Q(4) ID SUMMARY STATEMENT OF DEPICENCES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) COMPLETION TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (W 136) Continued From page 22 (W 136) note dated September 28, 2010, in which she documented that the wheelchair vendor had informed her that it was "broken beyond repair..." The QMRP and RD then presented a letter dated October 20, 2010, in which the wheelchair vendor wrote they "will be submitting the paperwork for approval by the insurance company." As of November 30, 2010, Client #2 remained without a custom molded gumey wheelchair and was confined to the hospital bed, within the facility. W136 On November 30, 2010, beginning at 6:00 p.m., This STANDARD will be met as review of Client #2's medical records revealed that he had missed ophthalmology and urology follows: 1. Cross-reference response to appointments originally scheduled for November 3, 2010 and November 9, 2010, respectively. In W127.2 Careco is in the process of obtaining a addition, the primary care physician (PCP) had J.30:11 Recreation Therapist. The ordered on October 1, 2010, laboratory studies Recreation Therapist will for "CBC, CMP, UA, TSH and floid profile." At 7:00 p.m., the CIMRP confirmed that the client complete assessments and had missed his ophthalmology and urology offer alternatives if the clients can't leave the home appointments due to the lack of a gumey for community activities as wheelchair. Since being confined to the hospital bed. Client #2 had not left the facility and, scheduled. therefore, his community integration was 2/30/11 restricted. It should be noted that his individual 2. Cross-reference response to Support Plan (ISP) dated November 9, 2009. indicated that "going to my day program and W127.3 Client#3 is using a community outings" were what is most important loaner chair. Careco is in to him. The ISP also included "It is important the process of obtaining a that i maintain optimal health, maintain a Recreation Therapist. The wheelchair that is in good repair and good Recreation Therapist will 2.30:11 relationships." complete assessments and offer alternatives if the 2. [Cross-refer to W127.3] On November 29, clients can't leave the home 2010, at 3:45 p.m., the left armrest on Client #3's for community activities as wheelchair was observed to be detached. scheduled. interview with the evening licensed practical

DEPARTMENT OF HEALTH AND HUMAN SERVICES

2/30/11

# PRINTED: 12/20/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION (X1) PROMDERWUPPLERICLIA (X2) MULTIPLE CONSTRUCTION (ALL) DATE SURVEY COMPLETED DENTIFICATION NUMBER: A. BUILDING R-C B. WING 00/3224 12/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE FOR 1/2 STITE STREET ME CARECO **WASHINGTON, DC 20019** SUMMARY STATEMENT OF DEPOSITIOES (EACH DEPOSITION MUST BE PRECIDED BY PULL REGULATORY OR LISC DISHTFYING REFORMATION) (X4) ID PROMDER'S PLAN OF CORRECTION (EACH CONNECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (XIII) COMPLETION PREFIX TAG TAG DEFICIENCY) **(W 136)** Continued From page 23 (W 136) nurse (LPN) revealed that the wheelchair had "recently" broken. The detached armrest had white adhesive tape wrapped around the bottom of one of its supports. Further interview revealed that facility staff previously used the tape to secure the armrest to the chair; however, the tape was no longer effective. At 7:20 p.m., interview with the QMRP and RD revealed the chair had broken a week earlier. As of November 30, 2010, the client had been without a functioning wheelchair for approximately one week and, therefore, confined to the interior of the facility. (W 140) 483.420(d)(1) STAFF TREATMENT OF **(W 140)** CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement its policies to ensure the health and safety, for six of the seven clients residing in the facility. (Clients #1. #2, #3, #4, #5 and #6) W149 The findings include: 1. Cross reference response to 1. [Cross-refer to W127] The facility falled to W127 12.8.10 ensure the health and safety of each client by 12/8/10 making certain that adaptive equipment was 2. Staff will be trained on the furnished and maintained in good condition transportation policy. In the (wheelchairs, air matiresses, shower chairs future the RD/OMRP will and/or gurneys) as prescribed, for Clients #1, #2. follow the appropriate #3, #4, #5 and #6.

2. Staff failed to implement the facility's

staffing pattern for the

home.

1.6.11

1/6/11

CENT	ERS FOR MEDICAR	AND HUMAN SERVICES  & MEDICAID SERVICES				PRINTED: 12/20/2 FORM APPROX OMB NO. 0838-0		
	NT OF DEPICIENCIES I OF CORRECTION	(X1) PROMDERBUPPLIER/CLIA IDENTIFICATION MANIBER:	()(2) I A BU		LTIPLE CONSTRUCTION UNIS	(X3) DATE SURVEY COMPLETED R-C 12/15/2010		
		893224	B. WI	NG				
CAREC	PROVIDER OR SUPPLIER O			STREET ADDRESS, CITY, STATE, ZIP CODE 606 1/2 67TH STREET ME WASHINGTON, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	STEMENT OF DEPICIENCIES  MUST BE PRECIDED BY FULL  BC IDENTIFYING INFORMATIONS	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECT	AD BE	COMPLETION DATE	
{W 149	transportation policy. On November 30, 2 left the facility with program. There we on the ven (no atterinterview with the revessed that the faleast one other staff drove clients in the however, that they amorning and that Claignificant behaviors approximately 7:25 transportation policy Policy B.1.b. "When an attendent (a pers	y, as follows: 1010, at 9:45 a.m., a driver Client #5 to take him to day is no other person observed idant). At 10:16 a.m., istidence director (RD) cility's policy was to have at i person on the van when they community. She explained, were short of staff that lent #5 usually did not exhibit	(W 1	145				
<b>N</b> 153}	report an injury of ur finger swollen, later timely, in accordance management policies beginning at approxime facility's incident revealed that injuries categorized as a seri policy specifies that are to be reported to manager and an incident fiderect support a staff (direct support a	of unknown origin were lous reportable incident. The serious reportable incidents the immediate supervisor or dent report generated. ented evidence that the and nursing) implemented ment policy as outlined.	<b>{</b> ₩ 15	<b>i3</b> }		ing an ly	1.5.11	

		TH AND HUMAN SERVICES IE & MEDICAID SERVICES			FOR	D: 12/20/2010 M APPROVED D: 0028-0201	
ITATELEN	TOF DEPICIENCIES OF CORRECTION	(X1) PROVIDERIGLIPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MUI	TIPLE CONSTRUCTION  NO	OMS NO. 0038-0301 (43) DATE SURVEY COMPLETED		
		00G224	B. WING		1	R-C	
CARECO			8	TREET ADDRESS, CITY, STATE, ZP CODE 606 1/2 67TH STREET ME WASHINGTON, DC 20019		15/2810	
(XA) ID PRIEFIX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY PULL  LISC IDENTIFYING INFORMATIONS	PREFIX TAG	PROVIDER'S PLAN OF CORNE (EACH CONNECTIVE ACTION & CROSS-REFERENCED TO THE AP DEPICIENCY)	OULDE	COMPLETION	
	mistreatment, neg injuries of unknown immediately to the officials in accords established proced.  This STANDARD Based on staff interpreted to ensure administrator and transition and transition in the facility failed to ensure administrator and transition in the facility failed to ensure administrator and transition in the facility failed to Client #1's finger report, Client #1's finger reported that #1's finger for November 23, 2010. Interview with the November 23, 2010, acknowledged noted that the points and was swotten worther finger close to exportedly was not prompress was application (PCP) was	name that all allegations of lect or abuse, as well as a source, are reported administrator or to other ince with State law through lares.  Is not met as evidenced by: rviews and record review, the sure that all injuries of the reported immediately to the he Department of Health for one of the seven clients lty. (Client #1)	{W 153	W153 This STANDARD will be refollows: The incident was initially reported to the incident was initially reported.  Administrator as a minor reconcern. It wasn't until Clie was taken for X-rays that revealed that Client #1 fingular fractured. Staff received service training on the identification and reporting incidents on 1/5/11. Staff will all injuries of unknown orices service training the identification and reporting incidents on 1/5/11. Staff will all injuries of unknown orices according to regulatory guidelies.	rted on the nedical ent #1 it was er was an in- timely g of report gin as cidents	12.1.10	

		H AND HUMAN SERVICES E & MEDICAID SERVICES				FOR	D: <b>12/20/2</b> 010 M APPROVED D. <b>0938-</b> 0391	
STATEME	NT OF DEPICIENCIES I OF CORRECTION	(X1) PROMOBERAL PPLENCIA IDENTIFICATION NUMBER:	1	MULTY	PLE CONSTRUCTION	(CO) DATE SURVEY COMPLETED		
		09G224	B. W	NG		R-C 12/16/2010		
CAREC	PROVIDER OR SUPPLIER CO			90	RET ADDRESS, CITY, STATE, ZP CODE 16 1/2 67TH STREET ME IASHINGTON, DC 20018	E, ZIP CODE		
(X4) ID PREFIX TAG			PRE	PIX	PROMDER'S PLAN OF CORRECT (EACH CONNECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPRICATION OF THE APPRICA	IN SHOULD BE COMPLETION IE APPROPRIATE DATE		
(W 153	day until resolved and to notify the ple of the medication a on December 3, 20 that the cold computatil November 23, Injury was discover On November 23, a.m., when asked vigenerated, the RD given to her by the management coord was a medical conclude to be written. In Nurse (RN) on November 11:30 informed of the bilis She assessed Clien November 17, 2010 finger was avoiten vifuger. The dented She informed the Pophysician ordered a results of the x-ray infractured.	and to monitor for infection hysician of changes." Review idministration records (MAR) 10, at 10:30 a.m. reflected ress treatment was continued 2010, ten days after the ed.  2010 at approximately 11:30 why an incident report was not stated that instructions were agency's incident instructions that shoe the injury tern that no incident report nierview with the Registered	{W	53)				
	November 17, 2010 approximately 10:00 incident was not rep until November 17, 2 bilster was discoven	on November 23, 2010, at a.m., revealed that this orted to the administrator 2010, four days after the id.						
The facility failed origin timely. W 158) 483.430 FACILIT		report an injury of unknown	{W 15	8}		; ;		
ł	The facility must and						1	

CENT	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES (X1) PROVIDENCUM						PRINTED: 12/20/2010 FORM APPROVED OMB NO. 0938-0301		
	NT OF DEPICIENCIES OF CORRECTION	(XI) PROMDENSUPPLENCLIA DENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONST	RUCTION	(CS) DATE SURVEY COMPLETED		
		093224	8. WE	<b>vo_</b> _				R-C /15/2010	
NAME OF	PROVIDER OR SUPPLIER			•	<b>1/2 57</b> TH	SOR, CITY, STATE, ZIP CODE I STREET ME FON, DC 20019		NGZS,U	
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCES MAINT BE PRECEDED BY FULL BC IDENTIFYING INFORMATION	ED PREPA TAG	K	ŒA	ROMDER'S PLAN OF CORRECT CH CORRECTIVE ACTION SHE S-REFERENCED TO THE APP DEFICIENCY)		COMPLETION DATE	
(W 158)	Continued From pa staffing requiremen	<del>-</del>	(W 1	58)		· · · · · · · · · · · · · · · · · · ·			
W 1503	Based on observation record review, the opprofessional (QMRF monitor, integrate, a safety needs of each ensure that each energicitive initial and enabled the employ duties effectively, and fall demonstrated complements at the facility's failure number of complement of complement of complement of the facility's failure number of complement of the facility's confessional (CMRP) client's adaptive equimonitored, for six of the facility's confessional (CMRP) client's adaptive equimonitored, for six of the facility's confessional (CMRP) client's adaptive equimonitored, for six of the facility's confessional (CMRP) client's adaptive equimonitored, for six of the facility's confessional (CMRP) client's adaptive equimonitored, for six of the facility's confessional (CMRP) client's adaptive equimonitored, for six of the facility's confessional (CMRP) client's adaptive equimonitored, for six of the facility's confessional (CMRP) client's adaptive equimonitored, for six of the facility's confessional (CMRP) client's adaptive equimonitored, for six of the facility is confessional (CMRP) client's adaptive equimonitored, for six of the facility is confessional client's adaptive equimonitored, for six of the facility is confessional client's adaptive equimonitored is confessio	ED MENTAL  OFESSIONAL  reatment program must be sed and monitored by a	{₩ 15	(a)	2.	Cross reference respon W189	13/11 se to /8/10 se to	1.13.11 12.8.10 1.30.11 12.8.10	

		HAND HUMAN SERVICES	·			FORM	: 12/20/2010 APPROVED . 0938-0391	
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENGUPPLIENCUA IDENTIFICATION NUMBER:		MLLT RLDO	IPLE CONSTRUCTION 43	(XS) DATE SURVEY COMPLETED		
		003224	B. W	NG_		R-C 12/15/2010		
CAREC	PROVIDER OR SUPPLIER 30				REET ADDRESS, CITY, STATE, ZIP CODE 108 1/2 S7TH STREET NE MASHINGTON, DC 20019			
PREFEC TAG	(EACH DEFICIENCY	TEMENT OF DEPCENCIES  MUST BE PRICEDED BY FULL  SC IDENTIFYING INFORMATION	PRES	PIX	PROMDER'S PLAN OF CORNEC (EACH CORRECTIME ACTION SHO) CROSS-REFERENCED TO THE APPR DEPICIENCY)		COMPLETION DATE	
{W 159	Continued From pa	ge 28	{W1	50}				
	ensure that clients' enable them to part in accordance with	• • • • • • • • • • • • • • • • • • • •						
	2. [Cross-refer to W189] The QMRP facility failed to ensure that each employee was provided with effective initial and continuing training that enabled the employee to perform his or her duties effectively and competently.							
	ensure that the direction competency in employer for clients with head	f192] The CMRP failed to at care staff demonstrated loying emergency procedures injuries, for the one client a documented head injury.	·					
W 189)	ensure that clients'; mattreases, shower furnished and meint Clients #1, #2, #3, #	436] The GMRP felled to prescribed wheelchairs, air chairs and/or gurneys were alred in good condition, for 4, 85, and 85. F TRAINING PROGRAM	{W 18	Ben .				
	The facility must pro	vide each employee with training that enables the n his or her duties						
	Based on observation review, the facility fall employee was provide	not met as evidenced by: n, interview and record lied to ensure that each led with effective initial and at enabled the employee to tles effectively and on of the fifteen staff.						

# PRINTED: 12/20/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES MB NO. 0038-0391 STATEMENT OF DEFICIENCES O(1) PROVIDERMUTPLERICLIA (02) MULTIPLE CONSTRUCTION (CC) DATE SURVEY COMPLETED WID FLAN OF CORRECTION DENTIFICATION NUMBER: A BUILDING B. WING 000334 12/12/2010 NAME OF PROVIDER OR SUPPLIES STREET ADDRESS, CITY, STATE, ZIP CODE 866 1/2 STTH STREET ME **CARECO** WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEPICIENCES (X4) ID PROVIDER'S PLAN OF CORRECTION EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LISC IDENTIFYING INFORMATION COMPLETION PREFEX CACH CONNECTIVE ACTION SHOULD BE ROSS REPERENCED TO THE APPROPRIATE TAG TAG CATE DEFICIENCY **(W 189)** Continued From page 29 **(W 189)** The findings include: 1. All staff were not effectively trained on the facility's newly-instituted administrative directive W189 regarding transportation of clients who utilize 1. a,b DSP and management wheelchairs for mobility, as indicated by the staff have been trained on following: how to follow directives. 12.8.10 This training will be [Cross-refer to W127.4.b and W127.5] After repeated annually and on an Client #1 died on November 24, 2010, the as needed basis. Staff are Governing Body issued a directive to keep a aware that no clients should client home if there was a problem with his or her 1.6.11 be transported if there wheelchair. This was again stated on November wheelchair is not safe. 29, 2010 upon receiving notice of the immediate 12/8/10, 1/6/11 jeopardy (iJ), at approximately 6:25 p.m. a. However, on the next morning (November 30, 2010), at 9:20 a.m., Client #4 was observed seated in his wheelchair on the lift mechanism of the facility's van. Observation of his wheelchair at that time revealed that the right anti-tipper was missing and the security straps on both footrests were unattached. b. Upon his return from day program on November 30, 2010, at approximately 4:45 p.m., observation of Client #5's wheelchair revealed that the safety strap on his left foot rest was broken. The client's records indicated that the strap had been broken since at least May 2010. Earlier that morning, at approximately 9:30 a.m., interviews with the direct care staff (at van side) had revealed that they were unaware of the administrative directive to keep a client home if there was a problem with his or her wheelcheir. At approximately 10:00 a.m., the QMRP

acknowledged that she was aware of the directive and that she had not informed her staff.

CENTE	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (1) PROMDERMUPPLEMCLIA D PLAN OF CORRECTION					PRINTED: 12/20/2 FORM APPROX OMB NO. 0838-0		
ITATEMEN NO PLAN	T OF DEFICIENCIES OF CONRECTION		1 '	MULTU MLDON	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		0 <b>0</b> G224	B.W	NG_	1	1	R-C <b>15/20</b> 10	
NAME OF I	PROMIDER OR SUPPLIER			81	MEET ADDRESS, CITY, STATE, ZIP CODE NS 1/2 S7TH STWEET ME MASHINGTON, DC 20019	I, CITY, STATE, ZIP CODE THERET ME		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEPICIENCIES Y MUST RE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	TX	PROVIDER'S PLAN OF CORRECT (EACH CONNECTIME ACTION SHOT CROSS-REPERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE	
(W 189)	Continued From pa	ge 30	{W 1	89}				
	effectively trained of monitoring, as followed in monitoring, as followed in monitoring, as followed in monitoring, as followed in monitoring in the start in a with monitoring and safety wheelchair, sustained subsequently died. Or defective wheelchair, #5 and #6.  a. On November 30 residence director (in recently instructed of document the condition of the "Shift Log/Deployment Experies a signature November 10, 2010 the "Shift Log/Deployment in the signature of the widence that the the first information review. Client #1's "Shift Log/November 14, 2010 revealed that staff information regarding wheelchair, including the or the staff in-service wheelchair Repair Wheelchair	27] On November 24, 2010, ported to and from a medical heelchair that did not meet his needs. He fell from the ad a head injury and Staff also had used broken hairs to transport Clients #3, 2010, at 2:10 p.m., the RD) stated that she had lirect support staff to tion of clients' wheelchairs on ment Sheet' form. Each shift inplets the form. She then re sheet documenting that on, she had trained 12 staff on syment Sheet' and other is signatures failed to show ree staff who were with Client			equipment.	safety uptive will staff th a chair	D.8.Q	

indicating that some direct support staff had

CENTE	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION  (X1) PROVIDENBUIPTLIENCUA IDENTIFICATION NUMBER:		(X2) MA A. BUIL	ALTIPLE CONSTRUCTION DING	PRINTED: 12/20/201 FORM APPROVE OMB NO. 0938-030 (CS) DATE SURVEY COMPLETED		
	-	093224	S. WIN	a		R-C	
CAREC	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZP CODE 806 1/2 57TH STREET ME WASHINGTON, DC 20019	12/15/2019 CODE		
(X4) ED PREFIX TAG	SUMMARY STATEMENT OF DEPICIENCES (EACH DEPICIENCY MUST BE PRISCEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)		PREFO	PROVIDER'S PLAN OF CORNE	CLAD BE	COMPLETION DATE	
	2009. There was need implemented to had implemented to October 7, 2009 transcrived additional and monitoring in the 2009. It should be 2010, at 4:00 p.m. It specialist/incident I indicated that he had training regarding to safety earlier that so however, provide an alleged training whe 29, 2010, at approxice QMRP and the RD at their corporate officipertaining to transposafety. No additions	in that form on October 7, to evidence that facility staff hat monitoring form after the sining or that staff had training on wheelchair safety to 13 months since October noted that on November 28, the Quality Assurance Management Coordinator of conducted in-service transportation and wheelchair that documentation of the in requested. On November imately 7:35 p.m., both the agreed to obtain records from the of any in-service training ortation and wheelchair all information was made before the investigation	{W 18				
W 1923	responded to Client: 2010 had received did. The facility faile responded appropria njury on November: from the driveway be by a medical profess 183.430(e)(2) STAFF	192] The three staff who #1's fall on November 24, ocumented training in first all to ensure that staff tely to Client #1's head 24, 2010. They moved him after he had been assessed ional.  TRAINING PROGRAM work with clients, training and competencies directed	{W 192	response to head injurie	staff on and ions. de a ound	1.30.11	

This STANDARD is not met as evidenced by: Based on interview and record review, the facility

DEPAR CENTE	ITMENT OF HEALT RS FOR MEDICAR	H AND HUMAN SERVICES E.A. MEDICAID SERVICES			FOR	D: 12/20/2010 M APPROVED	
STATEMEN	IT OF DISPICIENCIES OF CONNECTION	(XI) PROVIDERBUPPLENCLIA IDENTIFICATION NUMBER:	(X2) MULTI A BUILDIN	PLE CONSTRUCTION G	(ACS) DATE	OMB NO. 0038-039 (XS) DATE SURVEY COMPLETED	
***		00G224	B. WING		R-C 12/16/2010		
	NAME OF PROVIDER OR SUPPLIER CARECO			EET ADDRESS, CITY, STATE, 2P C 66 1/2 STTH STREET NE KASHINGTON, DC 20019		10/2010	
(X4) ID PREFFIX TAG	(EACH DEFICIENC	ATEMENT OF DEPICIENCIES Y MUST BE PRECEDED BY PULL LEC IDENTIFYING INFORMATION)	ED PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CONNECTIVE ACTIO CROSS-REFERENCED TO THE DEPOSITION.	N SHOULD BE E APPROPRIATE	(XB) COMPLETION DATE	
	failed to ensure the demonstrated corn emergency procedinguries, for the one documented head in the finding includes Review of an incide 2010, on November revealed that Client onto a concrete-covor the facility and suinterview with the Liapproximately 4:00 wheeled Client #1 in the client fell from his transferred from the that he assessed Client and determined and the time of the fall iscovering the client between the time of the fall iscovering the client proposed stunned and in the time of the fall iscovering the client proposed stunned and in the time of the fall iscovering the client proposed stunned and in the time of the fall iscovering the client proposed stunned and in the time of the fall iscovering the client proposed stunned and in the time of the fall iscovering the client proposed stunned and in the time of the fall iscovering the client proposed stunned and in the time of the fall is wheelchair, wheelen transferred him the time of the fall is wheelchair, where he was yet a nurse. Their into the fall is the fall is the time of the fall is wheelchair, where he was yet a nurse. Their into the fall is the f	It all direct support staff (DSS) patency in employing ures for clients with head client who had sustained a injury. (Client #1)	(W 192)	W192 This STANDARD will follows: The three staff involved on American Red Cross current certifications. Cawill provide a staff training around response injuries.	be met as was trained s and had areco, Inc. in-service	1.30.11	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (1) PROMOBRISHIPLENCIA DENTIFICATION NUMBER: (2) MULTIPLE CONSTRUCTION (C) DATE SURVEY COMPLETED (C) DATE SURVEY COMPLETED (C) DATE SURVEY COMPLETED (C) DATE SURVEY COMPLETED

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		003224	B. WA	MG		R-C 12/16/2010		
CARECO	OVIDER OR SUPPLIER			905 1	T ADDRESS, CITY, STATE, ZIP CODE 1/2 STTH STREET ME SHINGTON, DC 20019			
(X4) ID PRIEFIX TAG	(EACH DEFICIENCY	TEMENT OF DEPOSENCIES MUST BE PRECEDED BY PULL. IC IDENTIFYING INFORMATIONS	ID PREF TAG	ex	PROVIDER'S PLAN OF CONTREC (EACH CONTRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)		COMPLETION DATE	
W 331) 48 Tr se doi: On a.m detical blis	he in-service training activity revealed doc hat the three DSS is sertification. On Dec.m., review of the Arebetle confirmed the ead injury should no further danger." Staffective response to ituation.  83.460(c) NURSING the facility must proportion in accordance in accordance were transcribled to make the ead on interview a citity's nursing staffeters were transcribled (POs), for one citity. Ellent #1)  In finding includes: eview of the direct serview of the direct serview of the nursing staffet on his right index servation to the nursing staffet in on his right index fing the lower per terms of the activity right index fing ster to the lower per service to the lower per service of the lower per service in our per service to the lower per service in the lower p	010, at 11:00 a.m., review of g records maintained by the urnented evidence verifying indeed had current first aid cember 3, 2010, at 12:30 american Red Cross's lat a person who sustains a pot be moved unless there is inf failed to demonstrate an inclient #1's emergency.  SERVICES vide clients with nursing ce with their needs.  Inot met as evidenced by: and record review, the failed to ensure verbal ad onto a physician's order of seven clients in the	(W 3:		Physician's orders.  W436 This STANDARD will be follows: Cross reference response to W 1. Cross reference response to W127.1  2. Cross reference response response reference response re	the RN menting 1/30/11 met as 127 conse to 12/8/10 conse to 12/8/10 conse to 12/8/10 conse to 12/8/10 conse to 1/1/10 met 1/1/10	12.8.10	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/20/2010 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PNOVIDENGUPPLIENCLIA EXENTIFICATION NUMBER: (42) MULTIPLE CONSTRUCTION (XX) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A BUILDING R-C B. WING 000224 12/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE S 1/2 STTH STREET ME CARECO WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEPICENCES (X4) ID PROMDER'S FLAN OF CORRECTION (EACH CORRECTIME ACTION SHOULD SE CROSS-REPERENCED TO THE APPROPRIATE COMPLETION DATE EACH DEPICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LIC IDENTIFYING INFORMATION TAG TAG DEFICIENCY **(W 331)** Continued From page 34 (W 331) notified the primary care physician (PCP) and was ordered to apply a cold compress twice a day until resolved and to monitor for infection and to notify the physician of any changes. Review of the medication administration records (MAR) on December 3, 2010, at 10:30 a.m., reflected that the cold compress treatment was continued until November 23, 2010; however, review of the POs failed to show evidence that the nurse documented the order on the order sheet for the physician's signature. 483.470(a)(2) SPACE AND EQUIPMENT **(W 436) (W 436)** The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eveglacess, hearing and other communications aids, braces. and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility falled to ensure the health and safety of each client by maiding certain that adaptive equipment was furnished and maintained in good condition (wheelchairs, shower chairs and/or gurneys) as prescribed and/or provided transportation services, for four of the six clients currently residing in the facility. (Clients #2, #3, #4 and #5)

The findings include:

Cross-refer to W127. On December 15, 2010, Client #2's newly-delivered custom molded gumey wheelchair had not been assessed by the

		'H AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	D: 12/20/2010 MAPPROVED	)	
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA EXENTIFICATION NUMBER:	1	92) MULTIPLE CONSTRUCTION A BUILDING			CMS NO. 0938-0391 (CS) DATE GURNEY COMPLETED		
		090224	B. W	NO.		R-C 12/15/2010			
NAME OF CAREC	PROVIDER OR SUPPLIER  O			1	TREET ADDRESS, CITY, STATE, ZIP CODE 806 1/2 67TH STREET NE WASHINGTON, DC 20019		1.0.20.10		
(X4) ID PREFIX TAG	EACH DEFICIENC	ATEMENT OF DEPICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRE	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR		COMPLETION DATE		
	V 436) Continued From page 35 physical therapist and the facility had not secured transportation for him to access outside medical services. Client #3 remained without the prescribed shower gamey and custom molded wheelchair. His loaner wheelchair was inoperable on the day before, which led to his missing two medical appointments. Staff were observed moving Client #4 without putting the anti-tippers on his wheelchair in the down position, to ensure his safety. Client #5 remained without a shower gamey stretcher, and there was no evidence presented that the QMRP had brought the occupational therapist's November 1, 2010 recommendation for a shower gamey stretcher to the PCP's attention.  Previously, the Federal Deficiency Report dated December 3, 2010, included the following:  1. [Cross-refer to W127.1] The facility failed to obtain a custom molded wheelchair for Client #1. According to staff, the seat belt on the wheelchair the client was using on the day that he fell (November 24, 2010) had been broken for "approximately 30 days" prior to the incident. On November 29, 2010, at 7:00 p.m., observation of the wheelchair revealed that the seat belt was				DEFICENCY				
November 29, 2010, at 7:00 p.m., observation of the wheelchair revealed that the seat belt was indeed broken. In addition, the padding on the right arm rest was completely gone (the metal frame of the arm rest was exposed).  Problems with Clients #1's wheelchair were previously cited in an HRLA recertification deficiency report dated August 20, 2010. There was no evidence that the governing body									
] [	implemented their P submitted on Septen	lan of Correction since it was							

DEPAR	TMENT OF HEALT	H AND HUMAN SERVICES					APPROVED
CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES					. 0038-0301
	CENTERS FOR MEDICARE & MEDICAID SERVICES ATEMENT OF DEFICIENCES D PLAN OF CORRECTION  (X1) PROVIDERSUPPLIERCUA IDENTIFICATION NUMBER:  000224	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE 8 COMPLI	ETED	
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(W 436)	Continued From page 36 wheelchair had not been repaired, the QMRP had not maintained running notes in Client #1's records, and there was no evidence of quality assurance (QA) monitoring since the August 20, 2010 survey.  2. [Cross-refer to W127.2] Client #2 was admitted to this facility on September 7, 2010 with a broken hospital bed was broken (the head could not be elevated). It remained broken for an 83 day period between September 7, 2010 - November 29, 2010. His custom molded gumey wheelchair broke on September 25, 2010. Since then, he had been confined to a hospital bed and had not left the facility. This led to several missed medical appointments. In addition, Client #2 had received bed baths since his September 7, 2010 admission due to the facility's failure to obtain a shower gumey.			36)			
	admitted to the faci- recommendation the moided wheelchair, the client was witho wheelchair. The cli- a "rotting shower co- 28, 2010. As of No- was without a rotting addition, the client's the facility almost the mattress.  4. [Cross-refer to With maintain Chent #4's recertification deficit 2010, the facility we	V127.3] Client #3 was lity on August 5, 2010 with a at he receive a custom As of November 30, 2010, ut a custom moided ent's PCP wrote an order for mmode chair' on September vernber 30, 2010, the client pathower commode chair. In records showed that it took wree months to obtain an air  /127.4] The facility failed to wheelchair. In an HRLA mcy report dated August 20, s cited for Client #4's two different types of wheels					

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	IT OF DEFICIENCIES OF COMMECTION	(X1) PROVIDENCIA IDENTIFICATION NUMBER:	1 1	WLCON	IPLE CONSTRUCTION	(X3) DATE &	LIRVEY
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NAME OF I	PROVIDER OR SUPPLIER				MEET ADDRESS, CITY, STATE, ZIP CODE 106 1/2 57TH STREET NE MASHINGTON, DC 20019	<u> </u>	42010
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	the tire while the rig a smooth tire." In ti dated September 2: the "QMRP will con and have the chair maintain a log of co vendor and follow-u are effectuated as a QA will monitor for a compliance." Revie however, falled to a had implemented the not been repaired as previously identified wheels), the right an safety straps on both As of November 30, needed to take measured by would be without an another 30 days.  5. [Cross-refer to W repair the broken safet of Client #5's wheeld shower gumey that we four weeks earlier.  6. [Cross-refer to W repair or replace the	thit rear was observed to have heir Plan of Correction (PoC), 3, 2010, the facility stated that tact the equipment vendor repeired. The CMFP will entacts with the equipment up to ensure that the repairs bon as possible," and "the three months to ensure and in addition to the repairs needed (mismatched distipper was missing and the foot rests were unattached. 2010, the vendor still surements and the client appropriate wheelchair for 127.5] The facility failed to fety strap on the left footrest thair, and failed to order a was recommended by the OT 127.6] The facility failed to broken right footrest on ir in the six months since the	(W 4	38)			

STATEMENT OF DEFICIENCIES (X1) PROVIDENGUPPLIERICUA (X2) MULTIPLE CONSTRUCTION (ACS) DATE BURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0246 12/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 505 1/2 57TH STREET ME CARECO WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEPCIENCES (EACH DEPCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) (X4) ID PROMDER'S PLAN OF CORRECTION (08) COMPLETE PREPIX (EACH CONNECTIME ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) (1 000) INITIAL COMMENTS (1 000) A follow-up survey was conducted on December 15, 2010 to verify that the Group Home for Persons with Intellectual Disabilities (GHPID) had implemented their plan (submitted December 14, 2010) to resolve an immediate Jeopardy (iJ) that was found to exist on November 29, 2010. Through observations of the residents and their adaptive equipment. interviews with direct support, nursing and administrative staff as well as a review of the residents' records, the determination was made that the facility had not taken sufficient corrective action to remove the IJ. Specifically, the facility failed to provide transportation services and/or necessary adaptive mobility equipment to ensure that two (out of six) residents received outside medical services. [See |500] Previously, on November 24, 2010, at approximately 6:24 p.m., the Health Regulation and Licensing Administration 's (HRLA). Compliance and Quality Assurance investigation Division (CQAID) was notified by voicemail of the death of Resident #1. According to the message, the resident fell from his wheelchair. sustained a head injury and subsequently died while at the hospital. On November 28, 2010. the CQAID initiated an investigation to determine the facility's compliance with both Federal participation and local licensure requirements for intermediate Care Facilities for Persons with intellectual Disabilities (ICFID) participating in the Medicald program. On November 29, 2010, the Intermediate Care Facilities Division (ICFD) received a complaint from the Department on Disability Services that alih Regulation Administra

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STATEMENT OF DEFICIENCES O(1) PROVIDER/SUPPLIER/CLIA OCS) DATE SURVEY (X2) MAILTIPLE CONSTRUCTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A. BULDING B. WING\_ HFD03-0240 12/16/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 505 1/2 57TH STREET NE CARECO WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEPOSITIONS (X4) ID PROMOTERS PLAN OF CONNECTION (EACH CORRECTIVE ACTION SHOULD SE (AS) COMPLETE DATE CACH DEPOSENCY MUST BE PRECEDED BY PLAL.
REGULATORY OR LISC EXERTIFYING INFORMATION PREFIX PREFE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 1 {I 000} **{! 000}** affected residents in the facility did not have necessary adaptive equipment. The complaint further alleged that needed medical services were not being provided and the facility falled to implement dietary orders and mealtime protocols as required. A monitoring visit/investigation was initiated by the ICFD into the following allegations on November 29, 2010: 1. Resident #2's "wheelchair gumey" was reported by his occupational therapist (OT) as broken beyond repair. Allegation was substantiated. 2. Resident #2's scheduled medical follow up appointments, i.e., his annual ophthalmology follow up for glaucome and annual urology, have been cancelled due to "transportation" issues related to his wheelchair gumey. Allegation was substantiated 3. Resident #2's labs ordered by his primary physician on September 1, 2010, have not been completed. The nurse stated that the labs have not been completed due to the "transportation" issues. Allegation was substantiated 4. Resident #2 is prescribed a low fat, low cholesterol pureed dist with nector thickened liquids. On the date of the review, November 23, 2010, Resident #2's liquids were not presented in accordance to his prescribed diet and texture. He was provided "boost" liquid which was not thickened. Allegation was not substantiated 5. Resident #2 has a mealtime positioning plan to address his risk of aspiration and choking. His plan includes elevating the head of his bed to a

Health Regulation Administration

Health Regulation Administration STATEMENT OF DEPCHACES O(1) PROVIDER/BUPPLIER/CLIA **ACZ) MILITIPLE CONSTRUCTION** CAS DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A BUILDING S. WING. HFD03-0246 12/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 505 1/2 57TH STREET NE **CARECO** Washington, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFX PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC EDENTIFYING INFORMATION (XIII) MPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE PREFIX TAG TAG PATE DEFICIENCY {| 0003 Continued From page 2 (1 000) 20 degree angle and the using a positioning wedge to elevate the resident an additional 50 degrees during and following his mealtime. On the date of the review, he was not properly positioned during his mealtime as recommended. Allegation was not substantiated 6. The home has no system in place by which to monitor Resident #2's weight. A wheelchair scale is in the home but is not currently operational. Allegation was substantiated 7. Although the nurse and Qualified Mental Retardation Professional (CMRP) are aware that Resident #2's weight is not being obtained or monitored, there is lack of monitoring of Resident #2's food Intake. Allegation was partially substantiated 8. The facility does not have a positioning plan in place to address Resident #2's skin integrity. Allegation was substantiated 9. The facility was not monitoring/documenting Resident #2's bowel movements. Allegation was not substantiated The findings of the monitoring visit/investigation were based on observations at the group home. interviews, and the review of clinical and administrative records, including incident reports. Six of the seven residents currently residing in the facility were reviewed. One additional resident's records was reviewed for the death investigation. The results of the monitoring visit/investigation revealed that conditions found. posed an immediate and serious threat to the health and safety of residents residing at the

Health	Regulation Administr	ration				FORM	M APPROVE	)
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDENGUPPLE IDENTIFICATION NU HFT03-0246	ERCLIA MEER:	(CZ) MUL: A BULDI B. WING	TIPLE CONSTRUCTION	(CS) DATE COMP	r R	
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(I <b>000</b> )	Continued From pate facility.  On November 29, 2 p.m. the Director of Services (DDDS) w Jeopardy (iJ) exists the DDDS submitted however the plan w Agency.  Note: On November 47, Resident 1's right in The cause of the injurther be noted that completed due to the report includes deficinvestigation into this	2010, at approximate Developmental Discussion in the facility. At it it a plan to resolve the not accepted by the 23, 2010, an investigent #1. An incider, 2010, reflected the dex finger was fractionly was unknown. It is investigation was cleath of Resident; it is investigation to the investigation to t	nbilities rimediate hat time, he IJ, he State tigation nt report t ared, should as not	{I 000}				
	Sor.1 POLICIES Al Each GHMRP shall i manual describing th will follow which shall necessary to meet th served and provide g member.  This Statute is not m Based on interview a Home for Persons will (GHPID) failed to improcedure manual the policies to meet each the seven residents of \$1, \$2, \$3, \$4, \$5 and the findings include:	have on alle a written process and process and process to each respectively. The second review, the second review review, the second review review, the second review	or dures it is ident of illines it is outlined of illined or in its of	{l 160}			12-17-10	

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDENBUPPLIENCLIA OCS) DATE SLIPNEY (C2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **DENTIFICATION NUMBER:** COMPLETED A BUILDING B. WING HFD03-0249 12/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE 505 1/2 57TH STREET ME **CARECO** WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCES (X4) ID PROMDER'S FLAN OF CORRECTION (XB) XMPLETE CATE (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY [1 160] Continued From page 4 [1 100] 1. [Cross-refer to i500] The facility failed to 1160 ensure the health and safety of each resident by This STATUTE will be met as making certain that adaptive equipment was follows: furnished and maintained in good condition 1. Staff has been in-serviced (wheelchairs, air mattresses, shower chairs on Careco Inc, Adaptive and/or gumeys) as prescribed, for Residents #1. Equipment Policy #2, #3, #4, #5 and #6. 12.17.10 Procedures and Adaptive Equipment Protocol. 2. Staff failed to implement the facility's 12/17/10 transportation policy, as follows: 2. Staff will be in-serviced on Careco Inc. Transportation On November 30, 2010, at 9:45 a.m., a driver Policy. Henceforth staff will left the facility with Resident #5 to take him to be expected to have an 1.6.11 day program. There was no other person attendant in the van when observed on the van (no attendent). At 10:16 clients are being a.m., interview with the residence director (RD) transported. revenied that the facility's policy was to have at least one other staff person on the van when they drove residents in the community. She explained, however, that they were short of staff that morning and that Resident #5 usually did not exhibit algorificant behaviors. Later that day, at approximately 7:25 p.m., review of the facility's transportation policy, dated 2007, revealed Policy B.1.b. "When individuals are transported. an attendant (a person other than the driver) is assigned to accompany them to attend to their special needs." 3. [Cross-refer to i379] Facility staff falled to report an injury of unknown origin (Resident #1's 3. Cross reference response to finger swollen, later determined to be broken) timely, in accordance with the facility's incident Federal deficiency W153 12.1.10 management policies. On November 23, 2010. 12/1/10 beginning at approximately 1:00 p.m., review of the facility's incident management policy revealed that injuries of unknown origin were categorized as a serious reportable incident. The policy specifies that serious reportable

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDERIGUPPLERICUA OCS DATE SURVEY 02) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A BUILDING B. WING HFD03-0248 12/16/2010 NAME OF PROMOER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 606 1/2 57TH STREET ME CARECO WASHINGTON, DC 20019 (X4) ID SUMMARY STATEMENT OF DEPOSENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL D PROVIDENS PLAN OF CONNECTION (08) COMPLETE (EACH CORRECTIME ACTION SHOULD SE CROSS-REFERENCED TO THE AFTROPRIATE PREFIX REGULATORY OR LIC IDENTIFYING INFORMATION TAG TAG DEFICIENCY (1 160) Continued From page 5 **(1 160)** incidents are to be reported to the immediate supervisor or manager and an incident report concreted. There was no documented evidence that the staff (direct support and nursing) implemented the incident management policy as outlined. (1 180) 3508.1 ADMINISTRATIVE SUPPORT £ 1803 Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview, and record review, the Group Home for Persons with intellectual Disabilities (GHPID)'s qualified mental retardation professional (QMRP) failed to ensure each resident's adaptive equipment was coordinated and monitored, for six of seven residents residing in the facility. (Residents #1, #2, #3, #4, #5, and #6) The findings include: 1180 1. [Cross-refer to 1449] The QMRP failed to This STATUTE will be met as ensure that residents' wheelchairs were operable follows: to enable them to participate in community 12.8.10 outings in accordance with their annual plans. 1. Cross reference response to **I449** 2. [Cross-refer to 1228] The QMRP facility failed to ensure that each employee was provided with 2. Cross reference response to 12.6.10 effective initial and continuing training that 1228 enabled the employee to perform his or her 12/8/10 duties effectively and competently. 3. Cross reference response to **I500** 3. [Cross-refer to ISOO] The QMRP failed to

Health Requistion Administration STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION O(1) PROVIDER/EUPPLIER/CLIA 003 MULTIPLE CONSTRUCTION (AL) DATE BURNEY IDENTIFICATION NUMBER: COMPLETED A BLEEDING B. WING HFD03-4248 12/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 05 1/2 57TH STREET NE CARECO Washington, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES OCA ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIATE D (XS) MPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) PREFIX TAG DEFICIENCY {| 180} Continued From page 6 (1180) ensure that residents' prescribed wheelchairs, air mattresses, shower chairs and/or gumeys were furnished and maintained in good condition, for Residents #1, #2, #3, #4, #5, and #6. (1 228) 3510.5(e) STAFF TRAINING {| 228} Each training program shall include, but not be limited to, the following: (e) Resident 's rights: This Statute is not met as evidenced by: Based on observations, interview, and record review, the Group Home for Persons with intellectual Disabilities (GHPID) failed to ensure that each employee was provided with effective initial and continuing training that enabled the This STATUTE will be met as employee to perform his or her duties effectively follows: and competently, for fifteen of the fifteen staff. I. a.b Staff have been in The findings include: serviced on the Transportation policy to 1. All staff were not effectively trained on the 128 10 ensure safety and rights of GHPID's newly-instituted administrative directive clients are maintained. recording transportation of residents who utilize Additional training was wheelchairs for mobility, as indicated by the provided to all staff on following: following written and verbal directives. [Cross-refer to |500.4 and |500.5] After Resident 12/8/10 #1 died on November 24, 2010, the governing 2. a-c Cross reference body issued a directive to keep a resident home response to I500 and cross if there was a problem with his or her wheelchair. reference response to This was again stated on November 29, 2010 Federal Deficiency W189.2 upon receiving notice of the immediate jeopardy 12/8/10 (iJ), at approximately 6:25 p.m. See Response to Federal Deficiency W192 a. However, on the next morning (November 30, 2010), at 9:20 a.m., Resident #4 was observed 1/6/11

Health Regulation Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERIGUPPLIERICLIA **003 MULTIPLE CONSTRUCTION** OCS) DATE SURVEY DENTIFICATION NAMEER: COMPLETED A. BLELDING B. WING HF003-0246 12/15/2010 NAME OF PROMOER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 505 1/2 57TH STREET NE CARECO WASHINGTON, DC 20019 **BUMMARY STATISMENT OF DEPICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION (74) COMPLETE (EACH CONNECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREPIX TAG TAO DEPICIENCY) {| 228} Continued From page 7 {I 228} seated in his wheelchair on the lift mechanism of the facility's van. Observation of his wheelcheir at that time revealed that the right anti-tioner was missing and the security straps on both footrasts were unattached. b. Upon his return from day program on November 30, 2010, at approximately 4:45 p.m. observation of Resident #5's wheelcheir revealed that the safety strap on his left foot rest was broken. The resident's records indicated that the strap had been broken since at least May 2010. Staff, however, had transported him to day program earlier that day with the wheelchair in that condition. Earlier that morning, at approximately 9:30 a.m., interviews with the direct care staff (at van side) had revealed that they were unaware of the administrative directive to keep a resident home if there was a problem with his or her wheelchair. At approximately 10:00 a.m., the QMRP acknowledged that she was aware of the directive and that she had not informed her staff. 2. The facility failed to ensure that staff were 12.8.10 effectively trained on wheelchair safety and monitoring, as follows: [Cross-refer to i500] On November 24, 2010. Resident #1 was transported to and from a medical appointment in a wheelchair that did not meet his medical and safety needs. He fell from the wheelchair, sustained a head injury and subsequently died. Staff also had used broken or defective wheelchairs to transport Residents #3. #4. #5 and #6. a. On November 30, 2010, at 2:10 p.m., the residence director (RD) stated that she had

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THEST ADDRESS, CITY, STATE, ZIP CODE  GOLD SUBMINITY STATESHENT OF DEPOSITIONS (MACH REPROSEDED BY PLLL)  FREQUENCY MAPT SET PRESENCE OF PROJECTION (MACH REPROSEDED BY PLLL)  FREQUENCY MAPT SET PRESENCE ACTION (MACH REPROSEDED BY PLLL)  FREQUENCY MAPT SET PRESENCE ON THE ACTION (MACH REPROSEDED BY PLLL)  FREQUENCY Instructed direct support staff to document the condition of recidents' wheelchairs on a "SHIRT LogDeployment Sheet" and other topics. Review of the significant sheet documenting that on November 10, 2010, she had trained 12 staff on the "Shirt LogDeployment Sheet" and other topics. Review of the significant sheet documenting that on November 10, 2010, she had trained 12 staff on the "Shirt LogDeployment Sheet" and other topics. Review of the significant sheet was made evaluable for review. At 212 pm., review of Resident 81's "Shirt Log" sheets for the period November 14, 2010 - November 24, 2010 revealed that staff had not documented any information regarding the condition of the wheelchair, including the broken seal belt buckle.  b. On November 30, 2010, at 7:18 p.m., review of the staff in-envice training records revealed a Wheelchair Repair Monitoring Form had been developed in 2009. There was a signature sheet indicating that some direct support staff had recolved additional training on that form on October 7, 2009. There was no evidence that facility staff had recolved additional training on the staff had recolved additional training on November 29, 2010, at 4:00 p.m. the Quality Assurance Specials/Incident Management Coordinator indicated that he hed conclucted in-service training regarding transportation and wheelchair safety sentire that sare day. I be did not, however, provide any documentation of the alleged training when requested. On November			IDENTIFICATION NU		A. BLÆDE	NG	COMPL	ETED R
CARECO  SUBJECT STATES THE STREET NE  WASHINGTON, DC 20016  SUBJECT STATES STREET NE  WASHINGTON, DC 20016  SUBJECT STATES STREET NE  WASHINGTON, DC 20016  PROMISER PLAN OF CORRECTION  SUBJECT STATES  CONTINUED From page 8  (I 228)  Continued From page 8  Continued From page 8  Continued From page 8  (I 228)  (I 228)  Continued From page 8  (I 228)  (I 228)  Continued From page 8  (I 228)  (I 228)  Continued From page 8  (I 228)  Continued From Page Page 18  (I 228)  Continued From Page 18  (I 228)  Continued Fr	NAME OF F	RONDER OR SUPPLIER		STREET AD	DRESS CITY	STATE ZIP CODE		102010
FRESTIX SECULATORY ORLIC ELEMPTH NO INFORMATION  (I 228)  Continued From page 8  recently instructed direct support staff to document the condition of residents' wheelchairs on a "Shift Log/Deployment Sheet" form. Each shift was expected to complete the form. She then presented a signature sheet documenting that on November 10, 2010, she had trained 12 staff on the "Shift Log/Deployment Sheet" and other lopics. Review of the signatures failed to show evidence that the three staff who were with Resident 81 at the time that he fell had been in attandance. No other documentation was made available for review. At 2.12 p.m., review of Resident 81 staff Log/Deployment 24, 2010 revealed that staff had not documented any information regarding the condition of his wheelchair, including the broton seat belt buckle.  b. On November 30, 2010, at 7:18 p.m., review of the staff in-service training records revealed a Wheelchair Repair Monitoring Form had been developed in 2009. There was a signature sheet indicating that some direct support staff had received training on that form on October 7, 2000. There was no evidence that facility staff had received ratining on that form on October 7, 2000. There was no evidence that facility staff had received ratining on that form on November 28, 2010, at 4:00 p.m. the Quality Assurance Specialist/incident Management Condition training regarding transportation and viscolchair safety and monitoring in the 13 months since October 1, 2009, at 4:00 p.m. the Quality Assurance Specialist/incident Management Condition training regarding transportation and viscolchair safety earlier that same day. He did not, however, provide any documentation of the sileged training when requested. On November	CARECO	)		506 1/2 57	TH STREE	T NE		
recently instructed direct support staff to document the condition of residents' wheelchairs on a "Shift Log/Deployment Sheet" form. She then presented a signature sheet documenting that on November 10, 2010, she had trained 12 staff on the "Shift Log/Deployment Sheet" and other topics. Review of the signatures failed to show evidence that the three staff who were with Resident \$1 at the time that he fell had been in attandance. No other documentation was made eveilable for review. At 2:12 p.m., review of Resident \$1's "Shift Log" sheets for the period November 14, 2010 - November 24, 2010 revealed that staff had not documented any information regarding the condition of his wheelchair, including the broken seat belt buckle.  b. On November 30, 2010, at 7:18 p.m., review of the staff in-service training records revealed a Wheelchair, including the broken seat belt buckle.  b. On November 30, 2010, at 7:18 p.m., review of the staff in-service training records revealed a Wheelchair specif Monitoring Form had been developed in 2000. There was a signature sheet indicating that some direct support staff hed received training on that form on October 7, 2009. There was no evidence that facility staff had implemented that monitoring form after the October 7, 2000 training or that staff had received additional training on wheelchair safety and monitoring in the 13 months since Cubber 2009. It should be noted that on November 28, 2010, at 4:00 p.m. the Quality Assurance Specialist/incident Management Coordinator indicated that he hed conducted in-service training regarding transportation and wheelchair safety earlier that same day. He did not, however, provide any documentation of the alleged training when requested. On November	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY	FULL	PREPA	(EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE A	HOULDBE	COMPLETE
29, 2010, at approximately 7:35 p.m., both the QMRP and the RD agreed to obtain records from		recently instructed document the cond on a "Shift Log/Dep shift was expected then presented a sign that on November 1 staff on the "Shift Lother topics. Reviews thow evidence that Resident #1 at the trattendance. No other available for review Resident #1's "Shift November 14, 2010 revealed that staff information regarding wheelchair, including the staff in-service Wheelchair Repair I developed in 2009. Indicating that some received training on 2009. There was no had implemented the October 7, 2009 traineceived additional transitional training in the 2010, at 4:00 p.m. the Specialist/Incident is indicated that he had training regarding training training training training where 29, 2010, at approach 2010, a	direct support staff is store of reeldents' wis sloyment Sheet form to complete the form gnature sheet document. On 2010, she had to og/Deployment Sheet wo of the signatures: the three staff who stare that he fell had ser documentation with the fell had ser documentation with the fell had ser documentation with the fell had ser documentation of the condition of the process of the broken seat be direct support staff that form on October of the form on October was a signal of the training form a single of that form on October was a signal of the training on wheelchart in the form on October of the form on Movement of the fell on the fell october of the fell of the fell october of the fell on the fell october of the fell of the fell october october of the fell october october october of the fell october octob	neelchairs n. Each n. She nenting nined 12 et" and failed to were with been in as made sw of period 10 any is bit buckle. , review wealed a I been ure sheet hed ir safety botober iber 28, a nator ce seichair , the wember oth the	{1 228}			

Health Regulation Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER: OCS) DATE SURVEY (XZ) MULTIPLE CONSTRUCTION COMPLETED A MUNICIPAL CONTRACT B. WANG HFD03-0248 12/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 505 1/2 57TH STREET NE CARECO WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDEN'S PLAN OF CONNECTION (EACH CORRECTIVE ACTION SHOULD BE (XS) MPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL EFE CROSS-REPERENCED TO THE APPROPRIATE TAG REGULATORY OR LCC IDENTIFYING IMPORMATION TAG DEFICIENCY (1 228) Continued From page 9 (1228) pertaining to transportation and wheelchair safety. No additional information was made available for review before the investigation ended. 3. [Cross-refer to Federal Deficiency Report -Citation W192] The three staff who responded to Resident #1's fall on November 24, 2010 had received documented training in first aid. The 1.6.11 facility falled to ensure that staff responded appropriately to Resident #1's head injury on November 24, 2010. They moved him from the driveway before he had been assessed by a medical professional. (1 379) 3519.10 EMERGENCIES (1 379) In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which 1379 This STATUTE will be met as substantially interferes with a resident 's health. welfare, living arrangement, well being or in any follows: 12.1.10 Cross reference response to Federal other way places the resident at risk. Such notification shall be made by telephone Deficiency W153 immediately and shall be followed up by written 12/1/10 notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on staff interviews and record review, the Group Home for Persons with intellectual Disabilities (GHPID) failed to ensure that all unusual incidents that place a resident's health and welfare at risk were reported immediately to the Department of Health, for one of the seven residents of the facility. (Resident #1)

Health Regulation Administration STATEMENT OF DEPOSENCIES O(1) PROVIDER/GUPPLIER/CLIA **002) MULTIPLE CONSTRUCTION** OCH DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A BUILDING B. WONG HFD03-0248 12/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 505 1/2 57TH STREET NE CARECO WASHINGTON, DC 20019 CA D SUMMARY STATEMENT OF DEPICENCIES PROVIDER'S PLAN OF CONNECTION (AB) COMPLETE DATE (EACH DEPCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC EDENTIFYING INFORMATION) PREFIX PHERK (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) {1 379} Continued From page 10 {| 379| The finding includes: The Department of Health was notified on November 17, 2010 via facsimile of an injury of unknown origin to Resident #1's finger. According to the incident report, Resident #1 sustained a fracture to his right pointer (index) finger. The cause of the fracture was not noted on the incident report. An on-site investigation was initiated on November 23, 2010. Interview with the residence director (RD) on November 23, 2010, at approximately 10:30 a.m., revealed that when the incident was discovered on November 13, 2010, the resident had a bilster on his finger (origin was unknown). The corresponding nursing note dated November 13, 2010, acknowledged the staff's notification and noted that the pointer (Index) finger of the right hand was swollen with a blister to the lower part of the finger close to the paim. The finger reportedly was not painful to touch and a cold compress was applied. The primary care physician (PCP) was notified. The PCP ordered to "continue with the cold compresses twice a day until resolved and to monitor for infection and to notify the physician of changes." Review of the medication administration records (MAR) on December 3, 2010, at 10:30 a.m. reflected that the cold compress treatment was continued until November 23, 2010, ten days after the injury was discovered. On November 23, 2010 at approximately 11:30 a.m., when asked why an incident report was not generated, the RD stated that instructions were given to her by the agency's incident management coordinator that since the injury was a medical concern that no incident report had to be written. Interview with the Registered

Health Regulation Administration STATEMENT OF DEFICIENCIES OX1) PROVIDERIBUPPLIERICLIA 000 MEATIPLE CONSTRUCTION (CD) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A BUILDING B. WING HFD03-0248 12/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ACCRESS, CITY, STATE, ZIP CODE 505 1/2 S7TH STREET ME CARECO WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEPICIENCES (EACH DEPICIENCY MUST SE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) (XA) ID PREFIX PROVIDER'S PLAN OF CORRECTION (26) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEPICIENCY (1 379) Continued From page 11 (1 379) Nurse (RN) on November 23, 2010, at approximately 11:30 a.m., revealed that she was informed of the blister on November 18, 2010. She assessed Resident #1 on the next day, November 17, 2010. The RN stated that the finger was swollen with a dent at the back of the finder. The dented area had a dark discoloration. She informed the PCP of her findings and the physician ordered an x-ray of the finger. The results of the x-ray revealed that the finger was fractured. Further review of the incident report dated November 17, 2010, on November 23, 2010, at approximately 10:00 a.m., revealed that this incident was not reported to the administrator until November 17, 2010, four days after the blister was discovered. The facility failed to report an injury of unknown origin timely. (I 440) 3521.7(s) HABILITATION AND TRAINING () 4498 The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (\$) Opportunity for social, recreational and religious activities utilizing community resources. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with intellectual Disabilities (GHPID) failed to ensure that residents participated in community outings in accordance with their annual plans, for two of the seven residents of the facility. (Residents #2 and #3)

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROMDERHUPPLIERICLIA 0(2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A BUILDING R WWW HFD03-0246 12/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 505 1/2 57TH STREET ME CARECO WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (XA) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIME ACTION MINOLED BE (EACH DEPOSENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC EDENTIFYING INFORMATION) (AS) COMPLETE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {| 449} Continued From page 12 [1440] The findings include: 1. [Cross-refer to !500.2]. Resident #2 was admitted to this facility on September 7, 2010. On November 29, 2010, at 3:50 p.m., Resident 1449 This STATUTE will be met as \$2's custom molded gumey wheelchair was observed being stored in a supply room. It was follows: 12.8.10 1. Cross reference response to tilted to one side and the evening nurse 1500.2 and Federal explained that the frame was broken. Simultaneous interviews with the qualified Deficiency W127.2 12/8/10 mental retardation professional (QMRP) and residence director (RD) later that evening, at 7:12 p.m., revealed that the resident's purney wheelchair had been functioning properly when he was admitted. The gumey wheelchair broke, however, on September 25, 2010. They indicated that the gurney wheelchair was assessed, and the QMRP presented her progres note dated September 28, 2010, in which she documented that the wheelchair vandor had informed her that it was "broken beyond repair..." The QMRP and RD then presented a letter dated October 20, 2010, in which the wheelchair vendor wrote they "will be submitting the peperwork for approval by the insurance company." As of November 30, 2010, Resident #2 remained without a custom moided gumey wheelchair and was confined to the hospital bed. within the facility. On November 30, 2010, beginning at 6:00 p.m., review of Resident #2's medical records revealed that he had missed ophthalmology and urology appointments originally scheduled for November 3, 2010 and November 9, 2010, respectively. In addition, the primary care physician (PCP) had ordered on October 1, 2010, laboratory studies for "CBC, CMP, UA, TSH and Hold profile." At 7:00 p.m., the QMRP confirmed that the resident elth Recu on Administration

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDERIBLIPPLIERICLIA OCS) DATE SLIRNEY OCO MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A. HE III CHAIS B. WING HFD03-0246 12/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE 506 1/2 57TH STREET NE CARECO WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEPICIENCES (EACH DEPICIENCY MUST SE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) (X4) ID PROMDER'S PLAN OF CORRECTION (769) COMPLETE PREFIX CROSS-REPERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) {| 449} Continued From page 13 { 440} had missed his ophthalmology and urology appointments due to the lack of a curney wheelchair. Since being confined to the hospital bed. Resident #2 had not left the facility and, therefore, his community integration was restricted. It should be noted that his individual Support Plan (ISP) dated November 9, 2009. indicated that "going to my day program and community outings" were what was most important to him. The ISP also included "it is important that I maintain optimal health, maintain a wheelcheir that is in good repair and good relationships." 2. [Cross-refer to I500.3]. On November 29. 2010, at 3:45 p.m., the left armrest on Resident #3's wheelchair was observed to be detected. interview with the evening licensed practical 28.0 2. Cross reference response to nurse (LPN) revealed that the wheelcheir had I500.2 and Federal "recently" broken. The detached armrest had Deficiency W127.3 white adhesive tape wrapped around the bottom 12/8/10 of one of its supports. Further interview revealed that facility staff previously used the tape to secure the armrest to the chair; however, the tape was no longer effective. At 7:20 p.m., interview with the QMRP and RD revealed the chair had broken a week earlier. As of November 30, 2010, the resident had been without a functioning wheelchair for approximately one week and, therefore, confined to the interior of the GHPID. (1 500) 3523.1 RESIDENT'S RIGHTS (I 500) Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137. this chapter, and other applicable District and federal laws. dit Reculation Administration

AND PLAN	CARECO SUMMARY STATEMENT OF DEFICIENCES		61REET AC 595 1/2 5	A. BUILDIN B. WING	STATE, ZIP CODE	(CS) DATE SURVEY COMPLETED R 12/15/2010	
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	This Statute is not Based on observatireview, the Group intellectual Disability the health and safet certain that adaptive and maintained in general maint	met as evidenced by on, staff Interview at forne for Persons with the (GHPID) failed the equipment was fur tood condition (wheel or gurneys) as preact aportation services, currently residing in \$2, \$3, \$4 and \$5) at \$7.48 a.m. At molded gurney when facility by the wheel services (IDE vaical therapist (PT) the new gurney when tesident \$2's apocification at \$7.48 a.m. At molded gurney when the interview with the interview with the interview gurney when tesident \$2's apocification at \$7.48 a.m. At the new gurney when tesident \$2's apocification at \$7.48 a.m.	nd record  Ith  o ensure by making mished sichairs, ribed for four the  Ition to videnced  pital bed 12:30 elchair erim DS) would elchair sichair to c needs, red an  quality he had 's new her the ling the the	{1 500}	1 a-c Cross reference response to Federal Deficiency W127.2		12.8.10

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROMDERBLEPPLERICLIA OCS DATE SLINVEY **02) MULTIPLE CONSTRUCTION** AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING HFD03-0248 12/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ACCRESS, CITY, STATE, ZIP CODE **505 1/2 57TH STREET ME** CARECO WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEPICIENCES
(EACH DEPICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LISC IDENTIFYING INFORMATION) (X4) ED PROVIDER'S PLAN OF CORRECTION (205) COMPLETE PREFIX TAG (EACH CONVECTME ACTION SHOULD IN TAG CHOSS-REPI STENCED TO THE APPROPRIATE DEPICIENCY) (1 500) Continued From page 15 {| 500} have his "specialist" examine the vehicle and determine whether the facility would need to order additional tie down straps. in the facility's letter in response to the Immediate Jeopardy (IJ), dated December 14, 2010, the facility stated, "arrangements have been made with <transportation vendor> to transport Resident #2 to medical appointments in the absence of his wheelchair." At 1:40 p.m., interview with registered nurse (RN) revenied that an application form for such services had been transmitted via facsimile to the transportation vendor on the day before (December 14, 2010). According to the IDDS, at 3:25 p.m., the application process required 24 -48 hours to determine his eligibility for services. Moments later, review of the application form verified that it had indeed been dated December 14, 2010. At approximately 4:30 p.m., Resident #2's Service Coordinator with the Department of Disability Services (DDS) Introduced herself to the survey team. She stated that the transportation vendor previously identified by the facility had informed her approximately one was earlier that they did not transport residents who recide in intermediate care facilities (ICFs). At 4:50 p.m., during a teleconference with the facility's administrator and the state agency, the IDDS acknowledged that to date, no alternative transportation services had been sought. b. On December 15, 2010, at 10:15 a.m., review of Resident #2's medical record revealed a lab report indicating that serum and urine samples had been obtained on December 9, 2010. The lab report showed several abnormal readings including a high serum level for dilentin. Moments later, review of a nurse progress note dated December 13, 2010 revealed that a

	NT OF DEPICIENCIES OF CONRECTION	(X1) PROMDERBUPPLE EDENTIFICATION NU HFD03-0248		(/2) MATE A BULDON B. WING	PLE CONSTRUCTION		
NAME OF	PROVIDER OR SUPPLIER		1		TATE, ZIP CODE		
CAREC	0			TH STREET TON, DC 2			
(X4) ID PREFIX TAG	(EACH DEPOSENC	ATEMENT OF DEPICIENCE Y MUST BE PRECEDED BY LBC IDENTIFYING INFORM	PULL	ID PREPIX TAG			COMPLETE DATE
{I 500}	ilicensed practical lab results and had primary care physiservice that day. I same LPN documorder to decrease retest his dilantin lat 11:46 a.m., the come to the facility 2010) to obtain nervices approximately 4 iDDS and the DDS that Resident #2 happointments due in Previously, the reappointment reaches 2010 to December 15 without transportati therefore, not receip of the facility.  c. It should be note Resident #2 remain two months after it 9:45 a.m., interview a second 719A form shower gumey. Shower gumey. Shower gumey. Shower gumey is 13, 2010, failed to re13, 2010, failed to re13, 2010, failed to re13, 2010, failed to re14.	age 16 nurse (LPN) had revi I left a message on ti ician's (PCP) telepho On December 14, 20 anted the PCP's telep Resident \$2's dilentire evels on December 1 i.PN stated that a nur the next day (Decer w serum and urine so i.45 p.m., interview w i. Service Coordinator ad continued missing to the lack of transpo- ident had an ophthale eduled from Novemb 2, 2010. He did not, of the December 2, 20 larly, he missed a De- pointment which he eduled for November i, 2010, Resident #2 on services and was, ving medical service di that on December ed without a shower was ordered by the F v with the IDDS reven had been submitted e presented a 719A ( PCP on November 30 ev of the resident's co- professional (QMRP) pulpment, dated December the meantime, the PC	he ne	{1 500}			

STATEMENT OF DEFICIENCES. O(1) PROVIDERIGUPPLIERICLIA OCS) DATE SURVEY 0(2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING B. WING HFD03-0246 12/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 505 1/2 57TH STREET NE **CARECO** WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEPICENCIES
(EACH DEPICIENCY MUST BE PRECEDED BY PULL.
REGULATORY OR USC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION D (XII) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAO TAG DEFICIENCY {| 500} Continued From page 17 {| 500} to continue receiving bed baths while awaiting the shower gumey. The facility failed to maintain Resident #3's wheelchair to ensure that he received outside medical services, as evidenced below: a. On December 15, 2010, from 7:48 a.m. until 12.8.10 12:45 p.m., Resident #3 was observed in his 12/8/10 hospital bed. At 12:30 p.m., the wheelcheir 2. a,b Cross reference response to Federal Deficiency vendor arrived in the facility and repaired the safety belt on the resident's wheelchair. At 12:43 W127.3 p.m., interview with the LPN revealed that on the 12/8/10 day before (December 14, 2010), Resident #3's wheelchair seatbelt had been loose on the right side; the wheelchair was deemed unaste. The nurse further indicated that because the seatheit could not be secured properly, the resident had missed two medical appointments (wound care clinic and PCP) that were scheduled for December 14, 2010. At approximately 1:45 p.m., interview with the RD and IDDS revealed that the same seatbelt on the loaner wheelchair had been repaired previously, on December 8, 2010. Then on the morning of December 14, 2010, "the other side" of the scatbelt had "come loose." During the exit conference, at 5:00 p.m., the IDDS acknowledged that the facility had not made another wheelchair available for Resident #3 on the previous day, to ensure that he kept his appointments. b. In the facility's letter in response to the Immediate Jeopardy (LJ), dated December 14. 2010, the facility stated the QMRP was Tollowing the Medicare process for obtaining a custom molded wheelchair for Resident #3. < Wheelchair vendor> had indicated that

Health Regulation Administration

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDENGLIPPLIENCLIA **(C2) MULTIPLE CONSTRUCTION** CCS) DATE BURNEY AND PLAN OF CORRECTION DENTIFICATION MANDER: COMPLETED A. BUILDING B. WHIS HFD03-0248 12/15/2010 NAME OF PROVIDER OR SLEPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 505 1/2 57TH STREET ME CARECO WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCES (X49 IID PROVIDER'S FLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL (25) COMPLETE REFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LBC IDENTIFYING INFORMATIONS TAG DEPICENCY) {1 500} Continued From page 18 (1 500) Medicare is requesting face-to-face visit with his <PCP> before they will authorized payment for ... new wheelchair." At approximately 4:00 p.m., interview with the LPN revealed that Resident #3 had not had a "face-to-face" visit with the PCP The PCP, however, wrote a prescription for Resident #3 to receive a custom made: wheelchair and a rolling shower chair/commode with waist belt. She presented the prescription and corresponding consultation form, which had both been signed and dated December 14, 2010 by the PCP. At approximately 4:10 p.m., follow-up interview with the RN and the same LPN again revealed that the resident was not seen by the PCP on December 14, 2010. They further explained that the PCP "sees him frequently." 3. On December 15, 2010, at 8:37 a.m., Resident #4 was observed seated in his 3. Cross reference response to wheelchair. The wheelchair's anti-tippers were in Federal Deficiency W127.4 the up position. Interview with a direct support 12.8.10 12/8/10 staff who was working with the resident indicated that the anti-tippers were used to help support the wheelchair from tipping backwards, when going up a hill. The staff did not, however, state how the anti-tippers should be positioned. At 9:07 a.m., the staff was observed propelling the resident toward the door. The anti-tippers were still in the up position. At 9:15 a.m., the RD was observed pushing Resident #4 outside towards the van. Again, the anti-tippers remained in the up position. When brought to her attention a few moments later, the IDDS acknowledged that the anti-tippers were in the up position. She (IDDS) then intervened and instructed the staff to reposition the anti-tippers in order for them to be effective. The RD and direct support staff subsequently adjusted the anti-tippers to the down position to ensure the resident's safety.

Health Regulation Administration STATEMENT OF DEFICIENCIES (XI) PROMDERBUPPLERICLIA **6(2) MULTIPLE CONSTRUCTION** OCS) DATE SLEWEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING a. weng HFD03-0246 12/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 605 1/2 57TH STREET NE CARECO WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEPCIENCE (X4) ID PROVIDER'S PLAN OF CORRECTION D (EACH DEPONENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION (769) COMPLETE (EACH CONVECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) (1 500) Continued From page 19 (1 500) When interviewed by telephone at 8:50 a.m., the wheelchair vendor stated "the anti-tiopers should be in the down position whenever the wheelchair is moving." It should be noted that review of the staff in-service records, at approximately 2:30 p.m., revealed that on December 8, 2010, facility staff had received training on safety and positioning in wheelchairs. Observations on the moming of December 15, 2010, however. indicated that the training had not been effective. 4. In the facility's letter in response to the immediate Jeopardy (LI), dated December 14, 2010, the facility stated that Resident #5's wheelchair had been repaired and was in safe 4. Cross reference response to working condition. The response letter did not 11-1-10 reflect the recommended shower gumey Federal Deficiency W127.5 stretcher for bathing. On December 15, 2010, at 11/1/10 8:20 a.m., inspection of the resident's wheelchair confirmed that the safety strap on the left footrest had indeed been repaired. The resident, however, remained without a shower gumey stretcher, and there was no evidence presented that the QMRP had brought the occupational therapist's November 1, 2010 recommendation for a shower gumey stretcher to the PCP's attention. Previously, the Licensure Deficiency Report 1500 Federal Deficiency Report dated December 3, 2010, included the following: 12/3/10 12.8.10 1. a-e Cross reference 1. Resident #1, who died from head injuries sustained in a fall from his wheelchair on response to Federal Deficiency W127.1 November 24, 2010, was admitted to the GHPID 12/8/10 in July 2008. a. On November 29, 2010, at approximately 6:10 p.m., interview with the qualified mental on Administration

Health Regulation Administration STATEMENT OF DEFICIENCES (X1) PROVIDERIGUPPLIENCLIA OCS DATE SURVEY 000 MULTIPLE CONSTRLICTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A RIM DING B. WING HFD03-0246 12/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 505 1/2 57TH STREET NE CARECO WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING REFORMATION (26) MPLETE (EACH CORRECTIVE ACTION SHOULD BE CHOSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY {1 500} Continued From page 20 (1 500) retardation professional (QMRP) revealed that Resident #1 had initially been admitted with a custom molded wheelchair. The wheelchair, however, allegedly was repossessed by the wheelchair vendor shortly thereafter, due to problems with the payment. [Note: The QMRP was unsure of the actual date and review of the resident's record later that evening failed to identify the exact date on which his custom molded wheelchair was removed from the facility.] Further interview with the QMRP revealed that in December 2009, the facility enlisted the support of the resident's attorney in an effort to secure a custom molded wheelchair that Resident #1 allegedly had been using while residing with a former provider. Those efforts. however, failed and the CMRP acknowledged that the facility had not initiated the formel process towards obtaining a new custom molded wheelcheir b. On November 30, 2010, beginning at 10:00 a.m., review of Resident #1's physical therapy (PT) records revealed ongoing recommendations to obtain a custom molded wheelchair. His annual PT evaluation, detect September 22, 2008, included "consider a custom molded sesting system." Then on October 13, 2006, the PT documented that the standard wheelchair, with sling type seating (the one the resident was uning at that time of his death) was inappropriate. He wrote "He sits on his right itium. His trunk is shifted right. There is increased pressure on his right addits from the right arm rest. The seating system perpetuates his scollosis and deformities. He is at risk of skin breakdown." The PT again recommended a custom molded wheelchair. In the next annual evaluation, dated October 15, 2009, the PT wrote the resident "had not received the

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	appropriate wheeld "Follow-up with ner October 4, 2010, it annual evaluation is same recommendation wheelchair. The gothe recommendation wheelchair.  c. Similarly, review therapy (OT) recombeginning at 10:15 had repeatedly doo wheelchair did not evaluation dated 8 "the wheelchair did not evaluation dated 8 "the wheelchair revaluation dated 8 the wheelchair revaluation dated 8 the wheelchair evaluation dated 9 the wheelchair evaluation dated 9 the wheelchair evaluation of the CT again noted does not provide of positioning." Later after sustaining a had. On November 21 telephone interview person who had assisted and onto the November 24, 201 on the seat belt of it broken for "approvide to have the seat belt of it broken for "approvidence, however to have the seat belt of the seat	chair" and recomment of custom wheelchair he PT performed and at which time he repution for a custom moverning body failed tons for a custom moly of Resident #1's oct do on November 30, a.m. revealed that the remet his needs. An eptember 14, 2009, wide and the seat an upport. He is at great wheelch in and new wheelch ided" The resident on, dated September 1 that the standard will ptimel belence, post that month, the resident that month, the resident wheelch is the standard will ptimel belence, post that month, the resident month, the resident is the standard will ptimel belence, post that month, the resident is the standard will ptimel belence, post that month, the resident is the standard will ptimel belence, post that month, the resident is the standard will ptimel belence, post that month, the resident is the standard will be standard wi	c." On other sated the olded io address ided cupational 2010, he OT sident's OT included d back do at risk for A new heir are i's most or 11, eement 1, 2010, he eicheir ture, or fent died in., sort staff at from he feli buckle sen iere was attempted amber 29,				
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Health Regulation Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (XX) DATE SURVEY (X1) PROVIDERIBUPPLIENCLIA **602) MULTIPLE CONSTRUCTION** COMPLETED **DENTIFICATION MUMBER:** A PLECONG S. WOLZ HFD03-0246 12/15/2010 STREET ADDRESS, CITY, STATE ZP CODE NAME OF PROVIDER OR SUPPLIER 505 1/2 57TH STREET NE **CARECO** WASHINGTON, DC 20019 PROVIDER'S PLAN OF CONNECTION (EACH CORNECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (205) COMPLETE DATE (X4) ID (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LISC IDENTIFYING INFORMATION) PREFIX TAG TAG DEFICIENCY f) 500) {| 500} Continued From page 22 completely gone (the metal frame of the arm rest Was exposed). e. Problems with Residents #1 wheelchair were previously clied in an HRLA recertification deficiency report dated August 20, 2010. There was no evidence, however, that the governing body implemented their Plan of Correction (PoC) since it was submitted on September 23, 2010. The QMRP had not maintained running notes in Resident #1's records regarding needed repairs and there was no evidence of quality assurance (QA) monitoring since the August 20, 2010 SULVEY. 2. Resident #2 was admitted to this GHPID on September 7, 2010. Resident #2 did not receive 2. a-d Cross reference new adaptive equipment as prescribed (gurney response to Federal 12.8.10 wheelchair, shower gumey), and/or timely repairs Deficiency W127.2 to his existing adaptive equipment, as evidenced 12/8/10 below: a. On November 29, 2010, at 3:45 p.m., a repairmen was observed working on a hospital bad located in a back bedroom. The evening licensed practical nurse (LPN) indicated that the hand of this hospital bad, which belonged to Resident #2, could not be elevated. At 4:23 p.m., the LPN informed surveyors that the head of the hospital bad was now operating, which he then demonstrated successfully. At approximately 7:15 p.m., interview with the residence director (RD) revealed that the head of Resident #2's hospital bad could not be elevated for the 83 days since he was admitted to the GHPID, on September 7, 2010. b. On November 29, 2010, at 3:50 p.m., Resident #2's custom molded gumey wheelchair was observed being stored in a supply room. It

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was tilted to one side and the evening nurse explained that the frame was broken. Simultaneous interviews with the QMRP and RD tater that evening, at 7:12 p.m., revealed that the resident's gumey wheelchair had been functioning properly when he was admitted. The gumey wheelchair broke, however, on September 25, 2010. They indicated that the gumey wheelchair was assessed, and the QMRP presented her progress note dated September 28, 2010, in which she documented that the wheelchair vendor had informed her that it was "broken beyond repair" The QMRP and RD then presented a letter dated October 20, 2010, in which the wheelchair vendor wrote they "will be submitting the peperwork for approval by the insurance company." As of November 30, 2010, Resident #2 remained without a custom molded gumey wheelchair and was confined to the hospital bed, within the facility.  c. On November 30, 2010, beginning at 6:00 p.m., review of Resident #2's medical records	PREFE	(EACH DEPOSENCY	Y MUST BE PRECEDED BY	FULL	PREPIX	CROSS-REPERIENCED TO THE APPR	LDRE	COMPLETE DATE		
revealed that he had missed ophthalmology and urology appointments originally scheduled for November 3, 2010 and November 9, 2010, respectively. In addition, the primary care physician (PCP) had ordered on October 1, 2010, laboratory studies for "CBC, CMP, UA, TSH and lipid profile." At 7:00 p.m., the QMRP confirmed that the resident had missed his ophthalmology and urology appointments due to the lack of a gurney wheelchair. [Note: The appointments had been rescheduled for December 2010.] As of that evening, however, there was no finalized plan for obtaining the laboratory studies ordered on October 1, 2010. Since being confined to the hospital bad, Resident #2 had not left the GHPID and, therefore, his community integration was	{1 500}	was tilted to one si explained that the Simultaneous interlater that evening, resident's gurney witunctioning propert gurney wheelchair September 25, 201 gurney wheelchair presented her prog 28, 2010, in which wheelchair vendor "broken beyond repthen presented a lein which the wheelchair vendor "broken beyond repthen presented a lein which the wheelchair hospital bed, within c. On November 32 remain gurney wheelchair hospital bed, within c. On November 32 revealed that he haurology appointment November 3, 2010 respectively. In ad physician (PCP) ha 2010, laboratory strong appointments had in the lack of a gurney appointments had in December 2010.] If there was no finalizate being confine Resident #2 had no specific confined that the content was no finalizate being confine Resident #2 had no specific confine that the second confine tha	de and the evening is frame was broken. Views with the QMRI at 7:12 p.m., reveals theelchair had been by when he was admit broke, however, on 10. They indicated the was assessed, and the gair" The QMRI at the documented the had informed her the pair" The QMRI at a claim was confined to the facility.  The QMRI and the pair work for approver, as of November 2 chair vendor wrote the perwork for approver, as of November and was confined to the facility.  The QMRI a custom and was confined to the facility.  The QMRI a custom and was confined to the facility.  The QMRI a custom and was confined to the facility.  The QMRI a custom and was confined to the facility.  The QMRI a custom and was confined to the facility.  The QMRI a custom and was confined to the facility.  The QMRI a custom and was confined to the facility.  The QMRI a custom and was confined to the facility.  The QMRI a custom and was confined to the facility.  The QMRI a custom and was confined to the facility.  The QMRI a custom and was confined to the facility.  The QMRI a custom and was confined to the facility.	P and RD and that the lited. The hat the het the het the st it was and RD and by the 30, 2010, a molded the lited for D10, are er 1, C, UA, er CMRP his due to The r lowever, g the 1, 2010, d, 1,	{1 <b>500</b> }					

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	restricted. It should Support Plan (ISP) Indicated that "goin community outings to him. The ISP at that I maintain option wheelchair that is in relationships."  d. On November 25 interview with the ethe 83 days since head received bed by	d be noted that his in dated November 9, g to my day program? were what is most is no included "It is importal health, maintain a good repair and 7:16, dated September apponding 719A form admitted from a nurse on August 5, 2010, receive new adaptively and/or timely received and/or timely received sleeping in a His wheelchair was bedroom; its left amview with the evening armined armined the tape to seek; however, the tape to seek; however, the tape At 7:20 p.m., interview reveals and received and the tape to seek; however, the tape At 7:20 p.m., interview reveals and received and received the tape to seek; however, the tape At 7:20 p.m., interview reveals and received the tape to seek; however, the tape At 7:20 p.m., interview reveals and received the tape to seek; however, the tape At 7:20 p.m., interview reveals and received the tape to seek; however, the tape to seek.	2009, and important ortant a od important a od it that in int #2 facility's 15 p.m., 29, verified ey."  sing e epairs to enced hospital mrest g LPN by" a m of one id that ecure is was awaith	(1 500)	3. a-c Cross reference response to Federa. Deficiency W127.3	1	12.8.10

Health Regulation Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDENBUPPLIERICHA **02) MULTIPLE CONSTRUCTION** (ACS) DATE SURVEY DENTIFICATION NUMBER: COMPLETED A BLE DING S. WING HFD03-0246 12/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **505 1/2 57TH STREET ME** CARECO WASHINGTON, DC 20019 OL4) ID SUMMARY STATEMENT OF DEPICENCIES PROVIDER'S PLAN OF COMMECTION Ю (EACH DEPOSENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC EDENTIFYING INFORMATION (XII) COMPLETE GLACH CONNECTIME ACTION SHOULD BE ROSS REFERENCED TO THE APPROPRIATE PREFIX CROSS-RETER DATE DEFICIENCY {1 500} Continued From page 25 **{| 500}** on August 5, 2010, with that wheelchair, which was in operational condition at that time. On November 30, 2010, beginning at 11:18 a.m., review of Resident #3's ISP, dated September 7, 2010, confirmed that he utilized a wheelcheir and that it was functioning at that time. Further review of the record, however, falled to show documentation of when the wheelchair had broken. At 3:00 p.m., review of Resident #3's PT records revealed that he had been assessed while in the nursing home and measurements were taken for a custom molded wheelchair. On August 9, 2010, the PT again noted the need for a custom molded wheelchair. Further review revealed that a 719A form was generated on September 28, 2010, six weeks later. Another four weeks passed then on October 20, 2010, the wheelchair vendor wrote they "will be submitting the paperwork for approval by the insurance company." in a letter dated November 30, 2010. the wheelchair vendor indicated there were problems with the resident's Medicare number. The QMRP stated that she had given the vendor the resident's Medicare card later on that same day. As of November 30, 2010, the resident was without a functioning wheelcheir. b. On November 29, 2010, at 7:20 p.m., the QMRP and RD stated that Resident #3 had a decubitus ulcer on his secral area when he war admitted to the GHPID. On November 30, 2010. at 3:00 p.m., review of Resident #3's PT records revealed that on August 17, 2010, the PT had recommended an air mattrees to promote skin integrity. At 4:26 p.m., further interview with the QMRP revealed that the resident received the air mattress on November 13, 2010, almost three months after it was recommended by the PT. eath Regulation Administration

Health Regulation Administration STATEMENT OF DEPCHENCIES (X1) PROVIDERGUPPLIERICLIA IDENTIFICATION NUMBER: 0(2) MULTIPLE CONSTRUCTION (ACS) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A BLILDING S. WING HFD03-0246 12/15/2010 NAME OF PROMDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 105 1/2 57TH STREET NE CARECO WASHINGTON, DC 20019 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (28) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LEC IDENTIFYING INFORMATION TAG DEFICIENCY) (I 500) Continued From page 28 (I 500) c. On November 30, 2010, at 3:10 p.m., further review of Resident #3's 719A form, dated September 26, 2010, revealed that the PCP also ordered a "rolling shower commode chair." A month later, on October 20, 2010, the wheelcheir vendor wrote that they "will be submitting the paperwork for approval by the insurance company." In a letter dated November 30, 2010, the wheelchair vendor indicated there were problems with the resident's Medicare number. The QMRP stated that she had given the vendor the resident's Medicare card later On that same day. As of November 30, 2010, two months later, the resident was without a "rolling shower commode chair." 4. According to a Plan of Correction (PoC) dated September 23, 2010, the OMRP indicated that repairs would be made to Resident #4's 4. a,b Cross reference response wheelchair. As of November 30, 2010, the to Federal Deficiency 128.10 resident's wheelchair still had not been repaired W127.4 and the condition of his wheelcheir placed him at 12/8/10 risk, as evidenced below: a. On November 30, 2010, at 9:20 a.m., Resident #4 was observed seated in his wheelchair on the lift mechanism of the facility's van. At the time, staff were loading recidents to go to day program. Inspection of his wheelchair revealed that in addition to the previously identified repairs needed (mismatched wheels), the right anti-tipper was missing and the safety straps on both foot rests were unattached. After the problems with his wheelchair were brought to the staffs' attention, they continued to but him on the van. At that moment, surveyors intervened and asked staff if they were aware of the administrator's directive regarding wheelchair safety and not leaving the facility. Staff then indicated that they were not aware of their

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	administrator's dire previous evening. the directive ("resident," a wheelchair a staff began wheeling against the approximately four back to the home.  Record review on hat 9:50 a.m., revea September 11, 201 recommended that wheelchair consult small for his height while PT evaluated the writing "Chair is too extremity injury." C 28, 2010), the PCP and signed a 719A to October 20, 2010, the that they "will be suit approval by the insudated November 30 the GHPID that they he insudated November 30 the Tenew wheelchair. To be taken before a the "entire process she the "chirp wheels re to have ridges in the observed to have a stated September 23, but the "QMRP will condor and have the endor and have the	octive that hed been a conce they were info dent will not be transpiritly it is properly reports right foot was obtained as they made the company of the com	rmed of ported sired"), di the eerved or leir way beginning a ris too 2010, nourred, for lower stember lohair on rwiote ris for a letter formed and days."  I dated or level and days."	{I 500}	D. C. P. P. C. P. C. P. P. C. P. P. C. P. P. C.		

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(A) D PREFIX REGULATORY OF LICENSPINAL REPORTMENTON  (I) 500}  Continued From page 29  (I) 500}  (I) 500}  Continued From page 29  (I) 500}  Continued From page 29  (I) 500}  (I) 500}  (I) 500}  Continued From page 29  (I) 500}  (I) 500}  (I) 500}  Continued From page 29  (I) 500}  (I) 5	NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	DURESS, CITY, STATE, ZIP CODE					
### RECULATORY OR LIST IDENTIFYING INFORMATION)  [1 500] Continued From page 29  footnest. At approximately 8:40 a.m., staff was asked about the missing footnest. The staff went to the resident's bedroom and returned moments later stating that they were unable to find his footnest. At 10:15 a.m., staff indicated that Resident 86 had stayed home from day program due to the condition of his wheelchair. Later that day, at 3:10 p.m., review of an OT evaluation, dated May 12, 2010, revealed that the OT had identified a broken strap and foot plate. When interviewed a minute later, a daytime LPN and the Director of Nursing confirmed that the resident had been in need of a new footnest for months. They explained that his insurance company (an HMO) repeatedly had denied requests to have the wheelchair repaired. The GHPID failed to repair or replace the broken right footnest in the six month since the OT identified	CARECO									
footrest. At approximately 8:40 a.m., staff was asked about the missing footrest. The staff went to the resident's bedroom and returned moments later stating that they were unable to find his footrest. At 10:15 a.m., staff indicated that Resident #6 had stayed home from day program due to the condition of his wheelchair. Later that day, at 3:10 p.m., review of an OT evaluation, dated May 12, 2010, revealed that the OT had identified a broken strap and foot plate. When interviewed a minute later, a daytime LPN and the Director of Nursing confirmed that the resident had been in need of a new footrest for months. They explained that his insurance company (an HMO) repeatedly had denied requests to have the wheelchair repaired. The GHPID failed to repair or replace the broken right footrest in the six month since the OT identified	PREPK	<b>GEACH DEFICIENC</b>	Y MUST SE PRECEDED SY	FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI	ULDRE			
	{1 <b>500</b> }	footrest. At appropasked about the mito the resident's be later stating that the footrest. At 10:15 Resident #6 had st due to the condition day, at 3:10 p.m., indested May 12, 201 identified a broken interviewed a minute Director of Numresident had been months. They exprompany (an HMO requests to have the GHPID failed to refootrest in the six minutes the six minutes and the six minut	STREET SUBMINITY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LISC IDENTIFYING INFORMATION)  Continued From page 29 Interest. At approximately 8:40 a.m., staff was sked about the missing footrest. The staff was been about the missing footrest. The staff was been stating that they were unable to find his lotrest. At 10:15 a.m., staff indicated that esident #6 had stayed home from day programe to the condition of his wheelchair. Later the lay, at 3:10 p.m., review of an OT evaluation, atted May 12, 2010, revealed that the OT had intrified a broken strap and foot plate. When derviewed a minute later, a daytime LPN and the Director of Nursing confirmed that the sident had been in need of a new footrest for conths. They explained that his insurance company (an HMO) repeatedly had denied equests to have the wheelchair repaired. The HPID failed to repair or replace the broken rigotrest in the six month since the OT identified		(1 <b>500</b> )					